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ABSTRACT

The Grambling State University Minority Management Internship in Aging program described in this report was designed to provide internships to social work students to aid the minority elderly. The status of the elderly in the United States and the personnel and agencies that assist them are discussed in the following chapters: (1) "Introduction" (demographics, life expectancy and income); (2) "Personnel Needs, Training and Recruitment" (Administration on Aging efforts; salary and prospects for gerontology graduates; and two articles: "Personnel and Training: Perspectives from a State Agency," by Mary Bethel, and "Training and Recruitment: Experiences of a Local Agency," by Jo Ann Hodge); (3) "Lack of Minority Participation" (the special disadvantagement of minority elderly); and (4) "Efforts to Increase Minority Participation" (description of this project, including recruitment and selection of host agencies, recruitment and selection of interns, agreement and understanding, internship, monthly conferences and seminars, and evaluation and achievement). Appendices provide tables of statistical data supporting the report; list the host agencies and interns; and provide samples of the letters of agreement, conference reports, and intern performance evaluation form. Contains 117 references. (KM)

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Gerontology Training For Minorities

Pill Jay Cho

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AASCU/ERIC Model Programs Inventory Project

The AASCU/ERIC Model Programs Inventory is a two-year project seeking to establish and test a model system for collecting and disseminating information on model programs at AASCU-member institutions--375 of the public four-year colleges and universities in the United States.

The four objectives of the project are:

- To increase the information on model programs available to all institutions through the ERIC system
- To encourage the use of the ERIC system by AASCU institutions
- To improve AASCU's ability to know about, and share information on, activities at member institutions, and
- To test a model for collaboration with ERIC that other national organizations might adopt.

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Gerontology Training For Minorities

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PREFACE

This is a final report of the Minority Management Internship in Aging, a project funded by the U.S. Administration on Aging (AoA), awarded (No. 90AT0303/01) to Grambling State University (GSU). Publication of this report was made possible by that grant. Opinions expressed in this report are, however, those of the author, and do not necessarily represent the official policy of AoA.

Mr. Jim Green, the Project Officer at AoA, has been kind, patient, and supportive. He has always responded quickly to my questions and requests. Although the publication of this report has been delayed, he has been very understanding. I wish to take this opportunity to thank him for his assistance, cooperation, and encouragement.

I am greatly indebted to agency directors and supervisors who hosted, supervised, and trained our interns: Mrs. Earline Coody, Mrs. Jackie Harrell, Mrs. Helen Buttita, Miss Cathy Hopkins, Mrs. Melba Sandifer, and Mr. Van Rogers of the Louisiana State Department of Health and Human Resources, Office of Human Development, Division of Children, Youth, and Family Services, Monroe Regional Office; Mrs. LaNell Winston, Mrs. Louise Denton, Mrs. Carolyn Ezell, Mrs. Mary Knight, Mrs. Martha Stephens, and Mrs. Francine Zuber of the North Delta Area Agency on Aging; and Mr. Joseph Nastasi and Mrs. Margaret Land of the Ouachita Council on Aging (see Appendix D1). This project was made possible with their involvement, and the success of this project depended on their active participation.

Interns are what the project is all about: Anna Alford, Marion Brown, Antoinnette Douglas, Sarah Dunn, Pamela Green, Terri Green, Brenda Grover, and Jacqueline Pace (see Appendix D2). They were a bunch of highly motivated young ladies determined to contribute to the well-being of the older Americans, especially the minority elderly. They worked hard and learned a lot. The interns delighted the agency supervisors and directors as well as the project staff. I salute them for their hard work and sincere efforts to learn.

My colleagues at the GSU School of Social Work, Larcy McCarley, Terry McPhearson, Joanne Rhone, and Jannette Russell, have served as project liaisons. Their contributions played a major role in the success of the project. I cannot express my gratitude too much. Two other colleagues, Barbara Dicks and Dean Pearce, served as readers. Pearce read the first three chapters, and Dicks read the last. Their suggestions were valuable. I appreciate their help very much.

I am also grateful to Mrs. Mary Bethel of North Carolina Division on Aging, Raleigh; Mrs. Jo Ann Hodge of Union Council on Aging, Monroe, North Carolina; Mrs. Mary Knight of East Carroll Council on Aging; and Mrs. Irma Colvin, Mr. Cleveland Birdo, and Mrs. Nomie Farley of Jackson Parish for allowing me to

include their papers or poems in this report. Their contributions enriched the report.

None of these wonderful people is responsible for any flaws, errors, or weaknesses of this report. I assume total responsibility for them.

Pill Jay Cho
Grambling, Louisiana
June 1988

CHAPTER I

INTRODUCTION

David Broder, a well-known columnist, recently celebrated his father's 90th birthday. This occasion caused him to reflect on his perception of aging, which is not atypical. "Born in Poland and brought to this country as a boy, he is – so far as he or we know – the first member of his family to reach his tenth decade. He has now outlived his father by 25 years – a goal I will certainly not emulate or achieve." Broder (1985) then moves from his personal experience to what he calls a "larger phenomenon:"

> In that sense, he is part of a larger phenomenon, which is changing the face of America and redefining some of our traditional ways of thinking about ourselves. The number of very old people in the United States is increasing rapidly, and our view of them – and of ourselves – is changing just as fast.
>
> The fastest growing age group in this country is my father's gang – the over-80s. . . Since the late 1960s, life expectancy among the elderly in the United States has increased at historically un-precedented rates. . . Many experts project that by the year 2000, average Americans can expect to live to the age of 80 – almost 35 years longer than their grandparents who were around in 1900.
>
> Another – even more dramatic – measure of the change is found in Census Bureau projections of the number of centenarians, those who are past 100. In 1982, there were about 32,000 U.S. centenarians. By year 2000, we can expect to have more than three times as many – 108,000. And by 2080, they may number 2 million !

This larger phenomenon, that the U.S. population is aging, is attracting the attention of Broder and many other people. As shown in Tables A1 through A3 (see Appendix A), the life expectancy at birth grew from 47.3 years in 1900 to 73.7 years in 1980 and 74.7 years in 1985. It is projected to be 78.1 years in 2020, and 73.6 years for male and 81 years for female in 2050. The median age grew from 20.9 years in 1880 to 31.7 years in 1986; and is projected to be 33 years in 1990, and to reach 42 years in 2050 (see also Associated Press 1985; Gibbs 1988, p.70).

While long life has always been a goal of human beings, not until the 20th century has it been possible to affect human mortality and extend life expectancy. As Ken Dychtwald stated bluntly, "it used to be that people didn't age. They died" (quoted in Gibbs 1988, p.66). In 1000 B.C. life expectancy at birth was approximately 18 years. This condition changed very slowly. By the year 50 B.C. the average person could anticipate only 25 years of life. It was not until the year 1600 A.D. that life expectancy reached 32 years. When the United States was founded, a new born child could expect to reach 35. By the beginning of the 20th century, the average individual lived to only 49 years (Cutler and Harootyan 1975; Gibbs 1988, p.66; Peterson and Bolton 1980, p.2; Siegel 1976; Siegel and Davidson 1984).

Of course, the span of human life cannot be expanded indefinitely. The goal of gerontology is not to extend the upper limit of human life – now about 115 to 120 years of age – but to make the lives of the elderly less burdensome physically and more rewarding emotionally. The new focus, says John Rowe, is not on life-span but on health-span (Toufexis 1988, p.76). According to Rockstein *et al.* (1977), the average human being has a potential life span of approximately 110 to 115 years. Thomas Parr (1438-1635), an Englishman, is generally considered to be the oldest human for whom reasonably reliable documentation exists (Powers 1987). Thus, Harold Massie of the Masonic Medical Research Laboratory of Utica, New York, points out that "after the huge increase in life expectancy during the first 200 years of the nation, the rate of increase has recently leveled off. 'The dramatic gains are not as evident as before,' he says. 'You don't see the huge changes that were brought about by things like improved hygiene. In fact, we probably owe more to plumbers for the extension of the life span than we do to medical research'" (Powers 1987).

The rate of increase may have leveled off, but the lengthened life expectancy has resulted in a major growth of the elderly population which continues to grow. The proportions of the elderly grew from 3.4 percent in 1880 to 12.1 percent in 1986 (65 and older), from 1 percent in 1880 to 4.9 percent in 1986 (75 and older), or from 0.2 percent in 1880 to 1 percent in 1980 (85 and older). They are projected to reach 67 million or 21.7 percent (65 and older), 37 million or 12 percent (75 and older), or 16 million or 5.2 percent (85 and older) in 2050.

The number and percent of older persons in the U.S. are expected to peak between 2010 and 2025 when the cohort of the post-World War II baby boom reaches age 65 (Peterson and Bolton 1980, p.3). "Americans over 65 now outnumber teenagers" (Associated Press 1984). In 1981 there were five working-age Americans for each person 65 years and older. By the year 2020, the ratio will be 3.5 to 1 (Louis Harris and Associates 1981). "Within the United States about three and a half workers support one pensioner. This ratio will drop to two and a half within the next decade. In West Germany the ratio now is two to one and demographers calculate the ratio as one to one by the end of this century. Japan has a ratio of 12 to one. This will plunge to around two to one by the year 2000" (Toth 1985, p.5).

We have seen above that the U.S. population in general is getting old, and the older population itself is also aging. In the 1970s the 75-plus group was the fastest growing segment of the American population. "Four generation families" are becoming more common. In 1980s, the 85-plus population is the fastest growing age group in the country. This group is expected to triple in size between 1980 and 2020 and increase seven times between 1980 and 2050. By 1995 the population of the average U.S. town will have a make-up like Florida's current population. These trends have far-reaching implications for public policy, because it is generally the upper age groups who have the greatest need for health care, income maintenance, housing, transportation, and other services (Gibbs 1988, p.66; U.S. Senate Special Committee on Aging 1984, p.7; 1986, p.15). Let us briefly review these implications.

America used to be a society of and for youth. "You've seen it on TV and in advertisements. Who is associated with the glamorous, throbbingly exciting life-style? Mostly young people. They are at the pulse of entertainment, clothing, cosmetics, travel and advertising in general. That's not to say older people are not featured in the media also. They are. They sell denture cream, painkillers and laxatives. The overall portrayal of old age in Western cultures is negative. Though increasing attention has been focused on the aged, it is usually in the context of 'the problem of the elderly.' But why should the elderly be considered a 'problem' for society?" (Steep 1984, p.31).

Dychtwald similarly observes that we have designed America to fit the size, shape and style of a country that used to be, and what we used to be is young. Books and newspapers, with their tiny prints, are designed for wide young eyes, as is the lighting in public places. Buttons, jars and doorknobs are obstacles to those with arthritis. Traffic lights are timed for a youthful pace (quoted in Gibbs 1988, p.69).

Are these situations now changing? "In many ways, America is not yet ready for the vast social change that came upon it rather suddenly. No one ever expected America to age gracefully. How could the country of adolescent spirit, reckless politics, marathons, short skirts, unbounded energy and a restless imagination admit that its body is growing old?" But with the growing number and proportion of the elderly population, change is inevitable. "It may be that, with all the willfulness of youth, America is finding a new way to grow old. Far from fading away, the elderly seem to be brightening on the horizons of the mind, the family, the workplace, the community. Everywhere their role and presence are changing" (Gibbs 1988, p.66).

How are they changing? Politicians rush to court the gray vote. Politicians for years viewed the aged as a uniform group – physically and often mentally feeble, politically compliant, socially inert. The candidate who follows such views today risks being trampled by what one Congressman sweetly calls the 800-lb. gorilla. The American Association of Retired Persons (AARP), with 28 million members, is bigger than most countries. The Gray Panthers, with 80,000 members, pressures Congress on everything from health insurance to housing costs (Gibbs 1988, pp.66, 69).

In the 1880s, when German Chancellor Otto von Bismarck set the retirement age at 65, the average life expectancy was 45. No problem then. Today Americans could well live into their 90s and remain healthy too. People are still retiring at 65. But this picture is also changing, though slowly. Many volunteer for charity work. For others, the greatest luxury of retirement is returning to work – on their own terms. Corporations plumb a deeply skilled, reliable labor resource among the used-to-be and not-yet-ready-to-be retired (Gibbs 1982, pp.66, 68).

The activity and prosperity of America's retirees have not gone unnoticed on Madison Avenue. Where once the image of the elderly was of frailty, there are now energy and curiosity. There was a time when advertisers behaved as though no one past middle age ever bought anything more durable than panty hose. No more. Few marketing experts can ignore the fact that Americans over 50 earn more than half the discretionary income in the country. Madison Avenue prepares to tap a vast, long-ignored market. In time, through sheer force of gravity, the products themselves, and not just the ads, will be shaped for an older consumer. In years to come, huge industries will emerge as America changes its shape and form (Gibbs 1988, pp.66, 68).

The elderly are living longer, healthier and wealthier lives, like Broder's father and mother who "are able to live independently, in their own apartment, with only part-time assistance. They are among the lucky elderly, for they are sharing life together after almost 60 years of marriage, rather than experiencing the widowhood that is the condition of a large majority of their contemporaries" (Broder 1984). Fully half of all people now 75 to 84 are free of health problems that require special care or that curb their activities. Even in the very oldest group, those above 85, more than one-third report no limitation due to health (Toufexis 1988, p.76). "The majority of older Americans assess their health favorably, even though they may have a physical limitation. According to the 1981 National Health Interview Survey (HIS), conducted by the National Center for Health Statistics, 8 of 10 elderly persons described their own health as good or excellent when asked to compare their health with others of their age." In the 1982 HIS survey, the proportion was 65 percent (U.S. Senate Special Committee on Aging 1984, p.52; 1986, p.84).

In Broder's view, his father and mother "are more typical of the pattern, however, in their decision to retire [and move from Illinois] to the Sunbelt . . . Half the nation's elderly migrants have moved to the 12 Sunbelt states." Charles O'Brien, 65, of Brooklyn, N.Y. moved to Arizona "so he could play golf every day" (Johnson 1984). During the 1970-80 intercensus period, more than 1.6 million older Americans over 60 reported migrating from one state to another. "Martha Dierdre is 72 and worth about $300,000. Widowed five years ago, she lives in a $150,000 condominium in Los Angeles, drives an Audi, consults her broker weekly, and plays bridge on Tuesdays over tea and crumpets" (Gibbs 1988, p.70).

Broder's parents, O'Brien, and Dierdre are indeed "among the lucky elderly." For many, aging is accompanied by declining health, decreasing income, loss of self-respect, loss of social contacts, and the like. Despite rather positive self-assessment of their own health, chronic conditions are problems of aging. Acute conditions were predominant at the turn of the century, while chronic conditions are now the most prevalent health problem for elderly persons (see Table A4). Nearly one-half of the 65-plus group suffer from arthritis. More than four out of five persons 65 and over have at least one chronic condition and multiple conditions are commonplace in the elderly. According to the 1982 National Long-Term Care Survey, about 19 percent of the 65-plus persons have some degree of limitation (U.S. Senate Special Committee on Aging 1984, p.58; 1986, pp.86-88).

According to a social worker in Morristown, N.J., "many older people [who move to the Sunbelt] want a milder climate or to live in a place where there are other people their age. Most older people move away because they cannot afford to keep the house they own or cannot find affordable apartments" (Johnson 1984). However, those who own houses are "among the lucky elderly." Many do not own houses which they can sell and move to the Sunbelt. The gap in median family income between the elderly (65 and over) and the nonelderly (25 - 64) has continued to narrow (see Table A5). Poverty rates of the elderly (65 and over) and the nonelderly (18 - 64) have shown a similar trend. They are 12.4 percent and 11.7 percent respectively in 1984 (see Table A6). "The elderly are much more likely than the nonelderly, however, to have low incomes just above the poverty level. In 1984, 16.7 percent of persons aged 65 and older were in families with incomes between the poverty level and one-and-one-half times the poverty level. At the same time, only 9.6 percent of those under age 65 were in families with incomes which fell within this range (U. S. Senate Special Committee on Aging 1986, p.43).

Many elderly like Broder's parents, Charles O'Brien, and Martha Dierdre are healthier and wealthier. Therefore, not all elderly need or seek help or services from "others." But with the new prosperity and activity of the elderly "come other, less cheering images and prospects. Among them is the still haunting presence of the elderly poor, most of them widows, many of them black, collapsing into a safety net that cannot support their weight. The well-being of America's senior citizens, though far greater than 20 years ago, is by no means universal. Many are sick and getting sicker, as health care becomes prohibitively expensive" (Gibbs 1988, p.66). An increasing elderly population inevitably includes those who are poorer and sicker, and accordingly creates needs for support or services.

Much help and support can be and continues to be provided by their families. Financial responsibility is only one of several kinds, and perhaps not the most burdensome. An ailing parent, even in a distant city, can take an emotional toll on adult children. In many cases the parent may be living in the same town or the same house. Already, says Marjorie Cantor, "the family is the major source of support for the elderly. And there is no indication in the future that families will abandon them." Carl Eisdorfer says that "adult children spend a lot of time caring;

they make a lot of personal sacrifices." The support goes both ways. In fact, private transfers of money and assets within families are just as likely, if not more likely, to take place from old to young. Lydia Bronte says that "the traditional generosity of grandparents now takes the form of helping with college tuition, down payment on a house, furniture – not just a check every Christmas." These signs of interdependence and cooperation encourage policymakers, who agree that a family is a far better source of compassion than a federal agency, however well funded (Gibbs 1988, p.75).

Not all grandparents are able to help with their grandchildren's college tuition, or help with a downpayment on their children's house or furniture. Not all adult children are capable of helping their elderly parents financially, or both. Relatives, friends, neighbors, churches, volunteer organizations, and even corporations may and do offer help. In modern societies, however, private sector support tends to be limited, resulting in a greater public share of support and services.

The elderly are depending more on social security and other government programs than their own earnings. Table A7 shows that in 1968 elderly families depended on earnings for nearly half (48.2 percent) of their income, while only 24.2 percent of their income was from government programs (social security and public aids). In 1982 the ratio reversed to only 28 percent earnings and 33.9 percent government programs, of which 70 percent was for income maintenance (social security, other retirement, veterans retirement, and SSI) as shown in Table A8.

Increased dependency on government programs is due in part to the fact that more people are retired. In 1900 only one-third of the elderly (65 and older) was retired; the proportion increased to 70 percent in 1974 (Siegel 1976). Why do more workers retire? Some people think that many workers are forced to retire against their will. "It is in the industrialized, money-oriented cultures that the custom of retiring older people from the working force is most abrupt and traumatic. A diligent, wage-earning, productive worker at age 65 too often has become in one day's time a nonwage-earning dependent – suddenly old, cast out of the working community. What a waste!" This forces most of them into poverty (Steep 1984, p.33). Some people, on the other hand, argue that it is usually the workers' option to take early retirement. Shall we force them to continue working, even if they can afford to retire? Shall we mandate an early retirement to give jobs to younger workers, even if they are able and willing to continue working. These questions, though important, are beyond the scope of this monograph.

The economic cost of maintaining millions of adults outside the work force is enormous, e.g., $264 billion in 1986 (see Table 9). When Reagan came into office, health care costs for the elderly was $50 billion. It is expected to reach $200 billion by the year 2000. Without a change in the present system, pension and health care costs will account for more than 60 percent of the federal budget by 2040 (Gibbs 1988, p.70). Federal spending for the elderly in 1977 was nearly one-fourth of the total federal

budget or over $100 billion (Powell 1979). According to a Population Reference Bureau report, the federal government spent 27 percent of its yearly budget, $218 billion, on people 65 and older in 1984. The proportion could grow to an estimated 50 percent of the federal budget by 2025 (Broder 1985). Table A9 shows that the federal spending on the elderly grew from 24.9 percent in 1965 to 39.7 percent of the "budget" or 27.7 percent of the "outlays" in 1984, and is projected to reach 60.4 percent in 2040.

The median income of couples 65 and over in 1986 was about $22,000, which can go a long way when mortgages are paid up, children have left home, and there are few large purchases such as appliances, to worry about. Thus, Samuelson (1988a; 1988b) asserts that the elderly are no longer "needy," and that contrary claims are "myths." However, much of the improvement in the elderly's income is due to the growth of social security benefits and their automatic cost of living adjustments (COLAs), which went into effect in 1975 (U.S. Senate Special Committee on Aging 1986, p.56). Lester Thurow recently showed that thanks mainly to government programs, per capita income for the aged reached a par with the rest of the population in the 1970s and, with Medicare and food stamps figured in, actually gives them a higher per capita income than the nonelderly (Broder 1985).

At the time Lyndon Johnson launched his immense rescue mission, the Great Society, more than a quarter of all old people lived below the poverty line. In the popular imagination, being old usually meant a frail and lonely dependency, in which old women lived on cat food in Spartan apartments and relied on busy children or social workers for a ride to the doctor. Washington waged war on poverty among the elderly through two programs that helped rich and poor alike. Congress created Medicare in 1965. In 1972 it voted a 20 percent increase in social security benefits and linked them to the Consumer Price Index in an attempt to safeguard retirees from the double-digit inflation that was devastating young families. The percentage of elderly poor living below the poverty line has been cut from 20 percent in 1970 to 12 percent in 1984. Social security and Medicare, combined with other sources of income, have provided many of the elderly with a sense of security that their own parents never enjoyed and that they will not relinquish without a fight (Gibbs 1988, p.69).

If the elderly are no longer needy as Samuelson claims, that is in large part due to government programs. His call for reduced governmental programs for the elderly "because they are well-off" is therefore a self-contradiction. If these programs are cut as he recommends, the elderly will then be needy even by his own definition or standards. Shall we increase or decrease federal outlays for the elderly? Shall we make government payments to all elderly or only to the needy elderly? These questions are a very complex issue, which is beyond the scope of this monograph.

In fact, these issues "have come to be perceived as so large and pervasive that the family, voluntary agencies, or philanthropic organizations cannot adequately

address them. Only government resources can provide the needed financial base. Financial support to this group, new roles and meanings for longer life, social and health needs as well as new and innovative approaches, and the general awareness of the accomplishments of an aging society will all increase" (Peterson and Bolton 1980, p.5).

The political campaigns of elderly organizations are born of stark realities: the persistence of nasty pockets of poverty among the aged, the threat of catastrophic illness that faces every old man and woman and, above all, the prospects of cutbacks in benefits as Washington struggles to balance its budget. The programs that the elderly are fighting to preserve were created a generation ago, when the reform-minded leaders of the 1960s vowed to protect senior citizens from shameful destitution that had terrorized earlier generations (Gibbs 1988, p.69).

But the fervor with which the elderly lobby to protect their benefits seems incongruous and unforgivably selfish to younger people who see only the silvery life-style of the old rich. While no one proposes cutting off the truly needy, those lobbying for reform point out that thousands of millionaires receive a monthly social security check. Mrs. Dierdre deposits her $420 social security check at the beginning of each month. Her only grandchild, Paul, earns $16,000 a year working at a lumber yard in Portland, Oregon. His wife Karen brings in an additional $6,000 as a part-time secretary. They live in a two-bedroom apartment for $500 a month, where they raise their three-year-old daughter. When they deposit their paychecks, they agonize over the 7% deduction for social security tax and wonder if they will ever see that money again – unless, of course, they visit grandma (Gibbs 1988, pp.69,70,75).

"It is clear that we younger Americans are not going to turn our backs on the elderly or deny the medical or financial assistance that protects their dignity" (Broder 1985). It may be so clear to the Broder Bunch, but not so clear to Samuelson and Company who insist that such assistance should come from the private sector, not from the government. It may not be so clear to others, especially young people, who believe Washington is already doing too much for its aged (65 or older) citizens (39.7 percent of the federal budget for 11.8 percent of population in 1984, see Tables A2 and A9), a perception that could bring about a serious breach between the generations (Gibbs 1988, p.70).

It is very possible that conflicts between the working and retired populations over use of resources will escalate (Peterson and Bolton 1980, p.5). It is also possible to have an "age war" between youth advocacy groups such as AGE (Americans for Generational Equity) and elderly advocacy groups such as AARP. Already the emerging power of America's grandparents frightens many of their children and grandchildren. Some experts forecast a costly confrontation, in which embittered young people and embattled older ones fight with the most sophisticated political weapons over ever scarcer resources. While social security remains off limits under Reagan who continues his vows to cut social programs, Aid to Families with

Dependent Children was cut by 19 percent and school-meal programs by 41 percent between 1981 and 1984. Thus, Senator Moynihan argues that the U.S. may be "the first society in history in which a person is more likely to be poor if young than old." John Porter, Republican Representative from Illinois, calls the budget deficit an exercise in "fiscal child abuse." Of such sentiments and statistics is the fear of an age war born. Lured by high stakes and intuitive appeal, the lobbyists are swarming around the "generational equity" issue (Gibbs 1988, p.70).

Senior citizens deeply resent critics such as Samuelson who seem to begrudge them their independence or imply that anyone ever got rich on a $500-a-month check. While it is true that the elderly consume roughly a third of the nation's medical resources, Medicare cannot begin to cover all the costs of a long illness. Already senior citizens pay three times as much out of their own pockets for health care as the young do. Many retirees worked hard, lived frugally and saved carefully to guard against the nightmare of a destitute old age. Mrs. Dierdre thinks of her late husband, a warehouseman, who worked hard and saved for 30 years. (Gibbs 1988, pp.70,75).

Budget-conscious policymakers must already balance the competing claims of education, childcare and welfare programs against Medicare, catastrophic health insurance and numerous benefits for the elderly. Fortunately, social security is not likely to ignite an age war, because many elderly acknowledge its flaws and admit the system needs to be changed, while many young people support its basic principles. Such signs of mutual concern and interdependence reassure social scientists and policymakers. In fact, the whole age-war scenario, some charge, is a political distortion, designed to stir up passion and protest about what should be an issue not of age but of social justice. "I don't think it should ever be put in terms of equity, that there is a choice between the elderly and children," argues Alan Pifer. "The intergenerational equity debate is a diversionary and dangerous sideshow," insists Ronald Pollack. Such views are supported by opinion polls, which reveal that most children are grateful for social security because it relieves them of some of the responsibility for taking care of their elders (Gibbs 1988, pp.66,75).

When the elderly retire, they lose more than earnings with retirement. One of the dominant values in America is the Protestant/Puritan work ethic. Work provides the worker with status, identity, sense of worth and the like in addition to income. When they are out of work, therefore, many elderly adjust to a "new" life of leisure, but others have difficulty maintaining their self-esteem.

An increasing elderly population thus creates needs for more financial, health, social, and other services for them, although not all of them may need help or support from "others" including the government. These service needs in turn create needs for more people, trained personnel, to deliver these services to the elderly. The next chapter examines personnel needs, training needs, and training and recruitment of personnel in aging.

CHAPTER II

PERSONNEL NEEDS, TRAINING AND RECRUITMENT

We have noted above that the elderly population is becoming larger and growing rapidly, and that the increased elderly population means more services are needed for them. To provide these needed services, the federal government spent about $264 billion in 1985 (see Table A9). The expenditures are not, of course, the total picture of these services and programs, but they provide us with a pretty good picture of it.

The service needs and expenditures in turn create needs for more personnel delivering such services to the elderly. "The expansion of federally and locally funded programs for older people has opened major opportunities for employment . . . At a time when some traditional employment markets for college graduates have begun to contract, the opportunities in local, state, and federal programs serving older people have attracted the attention of both faculty and students, and that more trained personnel are needed to deliver these services to them" (Peterson and Bolton 1980, p.6).

"Services to older people require increasing numbers of personnel who have an understanding of the developmental processes of aging, an interest in working with this client group, and an understanding of the service delivery structure now emerging. Since service to older people is a labor-intensive undertaking, the potential opportunities are immense, and increased attention is being devoted to preparing individuals for current and future positions. . . As increased government funding for community programs and institutional care has become available, the demand for qualified personnel has increased and opportunities for gerontology graduates have expanded so that there is currently a shortage of well-educated professionals in many areas" (Peterson and Bolton 1980, pp.7,40).

In 1968 the U.S. Administration on Aging (AoA) made an attempt to assess the needs for trained personnel in aging, and published a report, **Manpower Supply and Demand in Aging and Training Programs and Training Needs**. A series of articles followed the report lamenting the lack of trained personnel in aging (Donahue 1970; Birren 1971; Birren *et al.* 1972; Woodruff and Birren 1974). In 1976 AoA revised and updated its 1968 report in cooperation with the U.S. Bureau of Labor Statistics (BLS), and published **Manpower Needs in the Field of Aging: The Nursing Home Industry**. This new AoA-BLS report stimulated a variety of predictions. For example, The **Occupational Outlook Quarterly** (1976) published a

whole issue on gerontologically related employment which provides a good overview of the types and levels of positions available (Peterson and Bolton 1980, pp.7,40). And, Clyde Helms, President of Occupational Forecasting, Inc., predicted that the need for geriatric social workers alone will exceed 700,000 by 1990 (National Association of Social Workers 1983, p.3).

To meet the increasing demand for trained personnel delivering services to the elderly, a large number of gerontology programs have mushroomed on campuses including numerous community colleges throughout the country. "For a time it was popular to question the reasons why there were so few higher education programs in the gerontological area. Now there is so much activity that the questions are shifting to the quality and purpose of these undertakings as we begin to examine the progress that has occurred" (Peterson and Bolton 1980, p.9).

The result of this proliferation of gerontology programs is not well documented. According to one source, it is surprisingly large. "By the end of 1969, ten universities had graduated only 82 persons trained for special careers in aging. . . Today, well over 1 million people have been trained to work with the elderly" (Rodkin 1986b, p.1). Rodkin does not elaborate, and therefore it is not clear whether these "well over 1 million" persons received training in colleges or whether they include those who received the on-the-job or similar types of training. Hodge (1984; this article is included in a later section of this chapter) notes that there are gerontology training by United Way, Red Cross, Police Department, Fire Department, and others. Wiggins' number may have included people with such "trainings."

In any case, the literature is now concerned with this *overproduction* of gerontology graduates. Many programs soon began experiencing great difficulties in finding jobs for their graduates. This unsatisfactory experience led to a conclusion that "the aging manpower needs exist, but jobs do not. This situation is evident in the historical imbalance between gerontology graduates and jobs in this field. For a time in the early 1970s, there were more gerontology graduates than jobs" (Peterson and Bolton 1980, p.40).

What are the reasons, if any, for this oversupply or the imbalance between the need for personnel and the availability of jobs? There appear to be several reasons. To begin with, the job projections were based on the elderly population projections. The number of trained personnel needs is, of course, a function of the size of the future elderly population. But the latter is only an indirect indicator of the former, because not all elderly need services, and not all needy elderly seek services. In other words, the projected size of elderly population does not always translate into the corresponding projected manpower needs or jobs.

Secondly, most manpower needs projections are based on the projected growth of agencies and institutions such as nursing homes, senior centers, home health care programs, transportation services, and nutrition programs, all of which

depend, to a great extent, on financial support from the federal government. Federal fundings stagnated or declined, especially during the Reagan Administration. "Often, these projections were based more on hope than on any valid formula for estimating program growth" (Peterson and Bolton 1980, p.39). Therefore, even if a large number of the elderly are in need of services, they seek services, and many of them are placed on waiting-lists, agencies may not be able to employ needed personnel due to the lack of financial resources.

A third reason is related to the issues of boundary or "turf." Gerontology is like demography, in which a large number of disciplines and professions are interested but few programs offer a major or a degree in it. Few universities have departments of demography. Similarly, gerontology is not usually considered a *discipline*, even as a multidisciplinary or interdisciplinary one. It is rather an *ancillary* field in a large number of disciplines or professions. Several colleges offer a master's degree in gerontology (Peterson 1985). Some universities have proposed the development of a Ph.D. or an applied doctorate degree in gerontology (Peterson and Bolton 1980, p.49). It is not known how many of these proposals have actually been implemented. It is not known, either, how many programs offer a baccalaureate degree in gerontology. At the undergraduate level, students are more likely to receive training in gerontology in one of the traditional disciplines or professions.

Thus, the concept of "gerontology graduates" is murky. "The employment of gerontology graduates is far from resolved, however. Most of the jobs have traditionally fallen into other professional categories – nursing, administration, social work, recreation, counseling, or community organization – and are often filled by graduates from these areas" (Peterson and Bolton 1980, p.40). Unless Peterson and Bolton refer to graduates from master's programs as these "gerontology graduates," the above statement does not make sense. Almost all undergraduate programs in gerontology are in these disciplines or professions, and therefore graduates from these disciplines or professions are also "gerontology graduates." In any case, this point highlights the confusion about the *lack of jobs for gerontology graduates*.

Fourth, there is a general problem of establishing programs on college campuses simply because they are "popular." Of course, it may be observed that vogue and fashion are not limited to the world of apparel industry but may be applied in the academic world as well. Thus, we saw that after Sputnik, science and engineering programs flourished on American universities. During the years of the Vietnam War and the War on Poverty, social work and social sciences multiplied. After Watergate, journalism programs proliferated.

Students now seem to flock more around computer-related programs and business administration. In part due to declining student enrollment and decreasing federal support, colleges and universities, especially smaller ones with more financial difficulties, tend to create almost any new programs, in order to attract

more students. In 1984 the Carnegie Foundation for the Advancement of Teaching conducted a survey of colleges and universities, and found that they are overemphasizing *careerism* resulting in the development of job-oriented programs, even when they are not consistent with the missions of the institution (Boyer 1987).

Gerontology programs have sprung up on many campuses, only because many agencies and programs, and therefore jobs have been created for aging services, and in part because training grants were available. Much of the financial support for these programs and grants came from the federal government. With more students trained in gerontology and less financial support for aging programs, it is inevitable that the supply-demand balance is negatively affected.

Fifth and finally, there is a question of whether or not unemployment of gerontology graduates is actually due to lack of jobs. As we have noted earlier, most jobs in aging have been created with federal grants. Positions made available with such "soft" money tend to be short-term, and often salary levels are low. Information from the National Data Base on Aging indicates that 59 percent of directors of AAA in 1982 and 97.9 in 1986 in the nation on aging had annual salaries of $25,000 or less (see Table B1). The position of AAA director "usually requires a master's degree. . . and may also require a number of years of experience" (Rodkin 1986a, p.12).

In contrast, the average teacher's salary for 1985-86 was $25,257, according to the National Education Association (1986; see Table B2). Teachers are not usually required to have a master's degree. If 97.9 percent of AAA directors with a master's degree makes less than the average teacher with a baccalaureate degree, other employees in the aging network are most likely to make less. The new gerontology graduates are not likely to qualify for AAA directors, but even if they did, they are not likely to accept a position which pays so low. They are much less likely to accept a lower paying job. This is probably why recruitment of personnel at a local agency is "happen chance" as Hodge (1984; this paper is reproduced in a later section of this chapter) noticed.

Given these observations, Peterson and Bolton's conclusion that "aging manpower need exists, but jobs do not" seems to be an exaggeration. Peterson's (1985) own later study found that 59 percent of 438 graduates with master's degrees in gerontology were employed full-time in aging services. The Ketron Corporation (1981) reviewed the Title IV-A programs, and found that 60 percent of those with gerontology degrees, baccalaureate or master's, and 35 percent of graduates with non-gerontology degrees were employed.

In FY 1983 there were more than 53,000 employees (and 700, 000 volunteers) in aging network agencies (U.S. Administration on Aging 1984). The Pennsylvania Department of Aging conducted a survey in 1981, and found that there were 7,297 employees in aging network agencies in that state (Sharp 1985). In FY 1983 the number in North Carolina was estimated to be somewhere between 1,500 and 2,000

(Bethel 1984; this article is reproduced in a later section of this chapter). A survey in 1987 disclosed that there were 1,238 employees in aging network agencies in Louisiana (Cho 1988).

These data show that jobs do exist for gerontologists, and probably gerontology positions will increase. The increase will, however, not be as great as predicted by some "high" estimates. A more realistic projection has recently been made by the Committee for Health Needs of the Elderly. "The number of full-time equivalent professionally trained social workers needed to serve older persons and their families has been estimated to be in the range of 40,000 - 50,000 in the year 2000, and 60,000 - 70,000 in 2020" (NIA 1987, p.70).

The Committee's estimate is limited to "social work personnel who are directly involved in health services and who contribute as key members of health care teams" (NIA 1987, p.14). Social workers will be needed also for housing, recreation, transportation, protective, and other services for the elderly. Thus, the total needed will exceed 70,000 by 2020, but not as high as 700,000 by 1990, as Mr. Helms has projected.

A detailed examination of personnel and training needs at a state level, and of training programs and recruitment of staff at a local level will expand our understanding of gerontological staffings. The following articles by Mary Bethel and Jo Ann Hodge are from speeches given at the Livingstone Conference on Gerontology held at Camp Caraway in Asheboro, N.C., on April 11, 1984. While they were included in the conference proceedings (Cho and Whitener 1984), the circulation of the proceedings was limited and information is still germane today.

PERSONNEL AND TRAINING: PERSPECTIVES FROM A STATE AGENCY
Mary Bethel

I am very glad to be here at this conference on "networking." There have been attempts in the past to bring educators and practitioners together, and these attempts have met with limited success. Therefore, I am excited about what we are doing here today. My comments are to set the background as to where we have been and where we are as a network, and to provide information on the educational opportunities that are now available for those working with older adults in North Carolina.

When I use the term "aging network," I mean by it all those persons including volunteers who work in programs funded by the Older Americans Act. The number of employees working in the aging network in North Carolina in FY 1983 is estimated to be somewhere between 1,500 and 2,000. Most of them have been working for less than 10 years, and many of them for less than five years. As you

recall, area agencies on aging did not begin until 1974 in North Carolina. Nutrition programs also began in that year. Today we have 342 nutrition sites in our state.

A study was done in Pennsylvania in 1981 to determine the characteristics of the people employed in aging programs in that state. Such a study has never been conducted in our state. Pennsylvania is different from North Carolina in that they have three times the number of older adults than our state has, and they have more financial resources for their programs. They use Title XX funds [and revenue from lottery (Sharp 1985)]. In North Carolina, Title XX funds are not allowed to be used for aging programs [and there is no lottery]. I do think, however, that the results of their study can help shed some light on our aging network in North Carolina. The Pennsylvania study found, among other things, that there were a total of 7,279 service providers which is broken down as follows.

Classified by level/ladder
- 761 in management and administrative positions,
- 1,137 in administrative support positions,
- 5,268 in direct services, and
- 113 in other categories.

Classified by service areas
- 297 in service management positions,
- 1,242 in information and referral services,
- 481 in counseling positions,
- 820 in center services,
- 718 in congregate meals programs,
- 865 in transportation, and
- 2,856 in other services.

Classified by tenure status
- 3,879 in permanent full-time positions,
- 2,305 in permanent part-time positions, and
- 1,095 in temporary positions.

As for educational attainment of these people, the study found that most of those in management and administrative positions had a college degree with some graduate work. Administrative supportive personnel typically had completed high school or at least had a GED. Persons in direct service positions typically had high school diplomas followed by those who had some post-secondary education.

In regards to seniority, persons in the positions of administration and management were found to have an average of 4.4 years with their agencies. Persons with high seniority were working in service management, while those with low seniority were doing counseling or were involved in the congregate meals program.

In looking at the age range, it was found that persons in administrative and management positions were typically age 46 to 60, and those involved in direct services were also generally 46 to 60 years of age. Older persons were most likely to be employed in the areas of service management, center services, and information and referral. Younger persons, on the other hand, were in the areas of counseling and transportation.

If information from this study holds true for North Carolina, we can see many things that will be of importance to those of us who are interested in planning education and training opportunities for people working with older adults in our state. First of all from the Pennsylvania study, we see that many of the people have been with their agencies for a short time. Also, probably many of those employed in the administrative support and direct service positions have limited training beyond high school and therefore their experience with higher educational institutions may be limited. From this I think we can safely say there would probably be a high demand for educational opportunities for people in the aging network.

In addition to persons working in programs funded by the Older Americans Act in North Carolina, there are other groups that may potentially be in need of training in gerontology. For instance, we have 26 adult day care centers, 219 nursing homes, 330 homes for the aged and disabled, 630 family care homes, and approximately 50 retirement facilities, some of which have licensed nursing homes connected with them. In addition, there are county departments of social services, area mental health centers and district health departments. There also are private health care service agencies that are springing up in great abundance in our state as well as many other agencies and organizations that are currently providing services and programs for older adults.

The population of older adults in North Carolina is growing rapidly. In 1980, there were 603,181 persons aged 65 or older. It is projected that this number will increase to 789,029 by 1990 and to 938,385 by the year 2000. As for the old-old (85 or older), the number in 1980 was 45,203. This is projected to increase to 65,996 by 1990 and to 102,850 by 2000. This is a 128 percent increase from 1980 to 2000. As most of us are aware, the old-old are the highest users of services. With the increased number of people in need of services there will be a need for more people working in the field of aging. Just for a point of comparison, the total population of North Carolina is projected to increase only 19 percent from 1980 to 2000.

There has been a phenomenal growth in the last three years as far as the availability of educational opportunities is concerned. I get several calls each month from people in educational institutions who are interested in starting gerontology courses or aging programs. Ten years ago, there was not much offered. Five years ago, there were limited offerings. Today, most every college offers something. All but one of the 16 campuses of the University of North Carolina system have aging courses. At least 13 private colleges have established aging programs. Of these 13, Duke's is a graduate program, one of the oldest in the nation, established in 1955.

Livingstone College, which brought us together today, has an undergraduate program started in 1971. We also have four community colleges that offer a geriatric care specialist program, and one has a geriatric technology program. Almost all schools are involved in the area of continuing education programs.

Our state agency is also doing many things. We are offering short-term workshops as well as in-depth training programs, and the state aging conference. Many of you are aware that we have had a Summer Institute of Gerontology for the past four years, and we will have a fifth one this year.

Some programs in the state started their educational gerontology efforts with monies they received from AoA, which first began to award grants to educational institutions in 1966. At that time, there was a lot of emphasis of using the money for student supports in the form of stipends and things of this nature. In 1974, the Title IV-A began and there was a change of philosophy. The emphasis was shifted to course development and training of people working in aging programs, especially nutrition site managers and AAA staff. In 1976, the multidisciplinary centers on gerontology started and more money was available to the state agencies on aging.

In 1978, there was money for the geriatric fellowship program and the minority research program. In 1979, the regional education and training programs, and Long-Term Care Centers came into being. In 1981, training monies began to decline and funds became more targeted. In 1982, the U.S. Office of Human Development Services started the coordinated discretionary funds grant programs. Many institutions in North Carolina have made applications, and some have been funded. Although monies are quite limited now, there are still federal funds available to educational institutions.

As far as our state agency is concerned, we have had a decline in the amount of monies we received from Title IV-A, but we believe that in North Carolina we have been able to maintain the quality of our training program by drawing on free resources and by expanding the training capabilities of aging network personnel. I do believe that in North Carolina we have a lot going on. We have many programs that have been around for a while that are on very firm footing and we have some programs that are just beginning and are in the early stages of development. We have a good tradition, but there are still things that need to be done. If we are to have good programs, it is very important that people in academic settings and practitioners work together to strengthen what we have and to develop programs where gaps exist. Programs cannot be developed in a vacuum. We have to have the cooperation and coordination between the practitioner and the educator.

TRAINING AND RECRUITMENT: EXPERIENCES OF A LOCAL AGENCY
Jo Ann Hodge

This is a very broad topic which I am not prepared to cover in its entirety. I shall be modest, and limit my discussion to problems, concerns, and recommendations regarding gerontology training and recruitment based on my personal experiences as Director of a rural County Office on Aging.

A. Training Opportunities

On the local level there have been many training opportunities such as those provided by junior and senior colleges, State Office on Aging, Area Agency on Aging, Agricultural Extension Services, United Way, Red Cross, Association for the Blind, Association of Ministers, and even Fire and Police Departments.

Our big problem, therefore, has not been the lack of training but time and money to utilize what is available. Often costs for travel, food and lodging are the prohibitive factors. The difficulty of keeping the program going while staff is away is another deterrent.

B. Types of Applicants

People often ask me why we do not hire people with gerontology training in the first place rather than hiring "just anybody" and then trying to train them on-the-job? The answer is surprisingly simple – so much employment in the field of aging is "happen chance." We usually don't know when we can employ because of the nature of funding sources for our programs. When funding becomes available, it is almost always on a short notice and for a short term (e.g., a year) only. Thus, unless we hire someone immediately, we will lose all or portion of the funding, and lose all or portion of this person's services. We have to and do hire just about anyone who happens to be available at the time. Over the years I have encountered a large number of people who happen to be around our agency at the times we needed to hire a staff or more. These applicants are of the following types.

1. Recent graduates

If they happen to have had a pleasant experience with an aged relative and the college or university they attended had an emphasis on aging and there has by chance been an available internship or practicum, they may be enthusiastic about the field of aging. However, recent college graduates applying for jobs at our agency are mostly those with no such training.

2. Career workers

Applicants with college degrees and employment history in areas other than gerontology need service level exposure, broad network experience and an understanding of the realities over theories. It is often hard for them to realize that positions and salaries available are not anywhere near what they think they are worth.

3. Mature workers
Applicants with varying degrees of educational background and experience may be interested in location and convenience of job and a pleasant working situation. They can be very flexible and adaptable to the realities of local service delivery.

4. Elderly persons
Finally, there are elderly persons wanting to reenter the workforce, at least, on a part-time basis. Education and experience of many of these applicants are quite limited, but they feel they know all about aging. These people need in-service training, and if and when they are hired, job descriptions are often changed as their capabilities change.

Those are the types of workers local agencies encounter. In small towns, turnover of the elderly staff is low. It is difficult to move them on to unsubsidized employment. Turnover among young employees, on the other hand, is greater. This creates a great loss, because they are in general involved in many different tasks. Young professionals are attracted to large cities, and may even live in a distant city and commute. Living and traveling costs become extremely expensive.

Recently, we received 75 applications for an advertised job opening. Their backgrounds ranged from those with no experience and degrees in fields unrelated to aging to those with several advanced degrees and overly qualified – from retired air force colonels to those with Ph.D. or two master's degrees as well as recent graduates from baccalaureate programs. The job may serve as a stepping stone or interim position until something better comes along.

C. Criteria for Selection

Given these different types and levels of applicants, what criteria should a local agency director apply to select one from so many? If a position is funded by Title V, restrictions as to age, income and priority of those hard to employ must be considered. If the position requires the worker to go into homes of elderly widows, the position must be filled by a woman. Other than these mandated by law, what criteria do we have or should we develop?

There seems no easy answer to this question. Based on my own experience, I can only offer the following suggestions. Among professionals, often several different backgrounds are better than having all employees one profession only. Suppose a small local agency is to have three professionals only. A staff consisting of a social worker, a nurse, and a home economist will make a good balance.

Geographical background and age of professionals also must be considered when these staff work directly with elderly in a Southern rural community. You might as well face it: a young professional from New York City who lives a very contemporary life style will find it hard to related in a rural community such as Union County, North Carolina.

A small non-profit agency may not have the benefits or constraints of a merit system or Department of Labor occupational titles as a guide but must get many jobs done by a few persons. The staff often gets the feeling that everyone has to be everybody at one time or another. We not only create original job descriptions and titles but rewrite the ones we have to coincide with funding requirements and staff vacancies.

D. Suggested Model

In concluding my thoughts and observations on issues related to gerontology training and to bring more effective delivery of services to the aged, I would like to suggest a model of organizational structure which may be ideal in a rural community.

1. Umbrella agency

The current practice is that heads of different units of a county government are coordinating several different programs whose funding sources and restrictions are unrelated. They need the ability to understand the political structure and relate to governmental commissions, boards of directors, planning councils, and the agency's need to coordinate services for the elderly. An umbrella agency dealing with planning, control, direction and philosophy of services to the aged is desirable. A county Office on Aging can, and should, assume the role of such an agency.

2. Director's qualifications

An ideal candidate for directing such an umbrella agency is someone with administrative and supervisory skills; knowledge of management, program planning, personnel management, creativity and insight; a knowledge and understanding of biological, physiological, and psychological needs of the elderly; and full understanding of the aging network, public benefits and services provided by other agencies.

3. Qualifications of service providers

The agency should be staffed with people trained in basics of gerontology: needs of the elderly, public benefits and services of other agencies. In addition, they need training in specific skills in a designated job such as transportation coordination for human services with the ability to purchase, maintain, and schedule transportation for all ages including the elderly.

4. Career ladder

There is also an urgent need of career ladder or some kind of standardization of qualifications for persons working in service to the elderly. Often people at AAA or state office of aging have little or no knowledge of what goes on at the service level. There is no assurance that anyone entering at the service level will have any opportunity to climb to a more responsible job or higher pay.

There is no standardization of salaries among aging agencies from county to county or state to state. In some areas jobs with little responsibilities or qualifications

pay high salaries and in other areas are minimal for highly qualified persons with great responsibilities. Salaries in aging network do not begin to measure up to salaries in other professional areas. Therefore, we often end up training persons who become well qualified to move on to other areas of human services.

As the elderly population increases and the demand for services follows, are we going to provide better or poorer services administered by "happen chance" service providers? Or will we know that there are providers across the state with specific training for specific jobs in the aging network, and with compensation appropriate for well trained professionals and service providers?

CHAPTER III

LACK OF MINORITY PARTICIPATION

Minority aging is one of the most underdeveloped areas of study in social gerontology, and was virtually ignored by dominant gerontologists during the field's early phases of development (Cuellar *et al.* 1982, p.14; Markides 1983, p.115). The Minority Aging Codification Project at San Diego State University found that there are less than 100 references to minority aging prior to 1971. By 1980 the number increased to 1,500. Among the earliest references are Wilson (1953), Barron (1953), Sherman (1955), Kanagawa (1955), Smith (1957), Nichols and Obrist (1958), Bessent (1958), and Hamlett (1959). "Together these represent the thrust, if not the sum total, of the minority aging research carried out during the 1950s. However modest, this beginning exhibits certain trends: it has a problem-oriented rather than basic research orientation; it is interesting that the first minority aging studies of other than Negro older persons were conducted among aging Japanese Americans; and it is also important to note that as early as 1958 some researchers were already addressing cross-group comparative questions, as well as questions of the effects of culture conflict and change on the lives of older ethnic minorities" (Cuellar *et al.* 1982, pp.14,15).

Although studies among aging Japanese Americans (Kanagawa 1955; Bessent 1958) were part of the first minority aging studies, many of the 1,500 studies "has concentrated on aging among blacks and more recently Hispanics (mainly Mexican Americans), with other ethnic groups receiving less attention . . . Most minority gerontologists agree that most of these studies suffer from one of the following problems: (1) abstracted empiricism, (2) paucity of reliable data, (3) theoretical and methodological deficiencies, and (4) failure to give sufficient consideration to the needs of minority elderly involved" (Markides 1983, p.115). Despite these deficiencies, the Minority Aging Codification Project considers minority aging, or minority gerontology, "a viable area of specialization with a future" (Cuellar *et al.* 1982, pp.36,37).

Given the limited theoretical development in general gerontology, and the critical view taken of most dominant gerontological perspectives by most minority gerontologists, it is not surprising that only a few studies have reported findings on minority elders in terms of more general gerontological theory (Cuellar and Weeks 1980, p.2; Markides 1983, p.116).

They may not be fully developed theories, but there are two major views on minority aging. Until better terms are found, they will be called in this monograph "positive" and "negative" perspectives. The positive perspective has two branches: the "age-as-leveler" and the "model minority."

Burgess (1960) perceived that the elderly are left out of meaningful social activity and their condition accordingly is a "roleless-role." Cross-cultural research has shown that the loss of status of older persons is related to the transition from agricultural to industrial economy (Cowgill and Holmes 1972). In industrial societies, the elderly lose their "postfigurative role" (Mead 1954). The loss of role or status is common to all elderly, minority as well as majority. If minority elderly persons lose their status, it's more because they are the aged than because they are minority. Comparative research has shown that the status of women in a variety of societies has deteriorated consistently with the transition from foraging and horticultural economies to agricultural economy, as men assumed roles with primary control over the means of production (Martin and Voorhies 1975; Melville 1980). Women's status in industrial societies has improved somewhat, but remains far from equality with that of men. If minority women fare worse than men, that's more because they are women than they are minority.

The age-as-leveler hypothesis thus "predicts a decline with age in the relative disadvantage of minority persons since all older people experience similar deprivations regardless of [race or] ethnicity" (Markides 1983, p.116). Some gerontologists go even beyond this, and talk about advantage, rather than disadvantage, of being minority elderly. According to Gelfand (1982, p. 105), one advantage of ethnicity is that it can provide informal support networks to people of all ages who claim to be ethnic. Cohen (1978, p.401) predicts that the greater the participation in ethnic group activities, the less persons feel alienated in contemporary society. Thus, "Cohen believes that this hypothesis helps to explain why ethnicity continues to be valued in the face of powerful assimilative forces in the larger society. But it also provides a clue as to the importance of ethnicity to older ethnic members . . . Ethnic group membership offers the possibility of interaction in informal networks based on this shared identity, as well as participation in more formal organizations or ethnic clubs" (Cool 1986, p.268). These observations are, however, primarily based on ethnic, rather than racial, groups such as the Corsicans in France, Portuguese-Americans, and Jewish-Americans (Cool 1980; 1981; Myerhoff 1978).

The model minority thesis applies only to one minority, Asian Americans. It postulates that Asian Americans are so well off that they can and do take care of their elderly themselves (Maguire 1980; Hopps 1982; Longres 1982). Therefore, they "no longer qualify as an underrepresented or disadvantaged group and therefore no longer qualify for protection under affirmative action laws" (Gould 1988, p.142). Much of this perspective is based on the public image, or the news media picture, of Asian Americans which is partly based on census data (see Table C1) and to a large extent based on the perceived scholastic achievement of the youth and economic achievement of the community (Doerner 1985, p.42; Wallace 1987). Asian American

scholars suspect that this thesis is used by top ranking universities to apply quotas to Asian American students, by local governments to deny minority status to Asian American businesses, and by service providers to discourage Asian Americans from obtaining public benefits and other services. In aging, this sentiment is well expressed by Lum (1983, p.87):

> The Asian American elderly are in "quadruple jeopardy." They are poor, minority, old, and non-English speaking. Yet, unlike other minority groups, Asian Americans have tried to maintain their social and economic structure with a minimum of visible conflict and consciousness-raising with the host society. Historically, they have accepted much racial prejudice and economic/social discrimination without voicing strong protest. In fact, Asian Americans frequently have been described as "the silent minority," "the quiet minority," or "the model minority."

The negative perspective on minority aging is more commonly known as the double jeopardy hypothesis. It was advanced in a descriptive statement published by the National Urban League (1964), which was based on an earlier essay by Barron (1953) and later expanded by Henderson (1965) and the National Council on Aging (1972). It was originally intended to highlight the relative disadvantage of aged blacks: they are old (a devalued status in the United States) and they are members of a minority group (which has suffered discrimination at the hands of the larger society), but it is now commonly used to describe the situation of the aged in other minority groups in addition to blacks (Canter 1979; Fujii 1976). Although it is not a theory *per se* but a description of an existing condition (Gelfand 1982, p.39), was not intended to be a theoretical postulate around which knowledge on minority aging would be organized, and therefore, has not been adequately formulated as such, it is now used in theoretical discussions on the effect of minority status on the process of aging (Lindsay 1975; Markides 1980a; 1980b; Markson 1979; Stephens *et al.* 1980).

The double jeopardy thesis may be viewed as a special case of a broader multiple-hierarchy model of stratification theory (Bengtson 1979; Foner 1979; Gordon 1978; Riley 1976; Riley *et al.* 1972), in which minority status is viewed as an added dimension of inequality along with age, sex (women), class (low-income), language (non-English speaking). When three or more of these factors are considered, we hear of triple, quadruple, or multiple jeopardies. However, the term double jeopardy is used in this monograph, as its primary focus is on "minority" (not exclusively blacks) and aging.

The double jeopardy hypothesis rests on the assumption that "old age itself constitutes a situation of jeopardy. To what extent this assumption is established by empirical data is not as clear as it might at first appear," although there "is little disagreement in the literature that the income of older people in the United States and other industrial societies is considerably lower than that of middle-aged people" (Markides 1983, pp.118, 119). In fact, we have seen in Chapter I that there are some

who view the elderly in a much more positive way: the elderly are no longer needy or frail but wealthier and healthier.

The double jeopardy hypothesis also rests on the assumption that minority status itself constitutes a situation of jeopardy. This assumption is supported by theory and data. Social stress theory as applied to minority groups (Antunes *et al.* 1974) suggests that members of minority groups, in addition to bearing the deprivations associated with low social class, must face the added stress of discrimination and oppression associated with minority status and are expected to exhibit higher levels of psychological distress than members of the dominant majority at the same level of social class. The greater levels of psychological stress in lower classes are reported in community surveys and psychiatric epidemiology (Dohrenwend 1970; 1973; Dohrenwend and Dohrenwend 1969; Fried 1975; Kessler 1979). More recent literature in this area emphasizes that lower class people experience more psychological distress not only because of greater exposure to stressful events, but also, and more important, because they have fewer economical and psychosocial resources for coping with stress (Kessler and Clearly 1980).

The same can be said about the minority elderly. The resource deficit experienced by the aged is even more acute among minority elderly, as Varghese and Medinger (1979, p.97) noted: "Not only are the minority aged exposed to greater number of stressors, they also have fewer coping resources after a lifetime of financial deprivation, subordination to other groups, and systematic exclusion from access to social and economic opportunity."

Thus, there is "widespread agreement in the literature that elderly members of ethnic minority groups are socioeconomically disadvantaged compared to elderly members of the majority group. The double jeopardy hypothesis, however, predicts that the disadvantage of the minority persons is greater in old age than in middle-age (Markides 1983, p.120).

Dowd and Bengtson (1978) tested the double jeopardy hypothesis using a cross-sectional sample of aged (45 to 74) blacks, Mexican Americans, and whites in Los Angeles, and found empirical support for this prediction: the relative decline in income associated with age was significantly greater for blacks and Mexican Americans than for whites even when controls for socioeconomic status, sex, and health were introduced.

A study using a large national sample of blacks and whites (Ward 1980) found that, with educational and occupational differences controlled, there is some leveling of income differences between races in old age. Other available cross-sectional data (National Center for Health Statistics 1978; U.S. Administration on Aging 1980, Table 8; U.S. Bureau of the Census 1979, Table 24; Whittington 1975) support Ward's findings, and are not consistent with Dowd and Bengtson's data (Markides 1981; 1983, p.120-121).

Dowd and Bengtson (1978:432) also found that even with socioeconomic status, sex, and income held constant, older blacks and Mexican Americans were more likely to report poorer health than were older whites, and concluded that the double jeopardy hypothesis was supported. The data analyzed by Ward (1980) supports neither the double jeopardy hypothesis nor the age-as-leveler hypothesis. Substantial evidence from national data (National Center for Health Statistics 1978; 1980, Table 1, Table J) suggests that the health disadvantage of blacks compared to whites is greater in middle than in old age, with some leveling of differences with age. The few data on Hispanics provide no conclusive evidence in support of either leveling or widening of differences with age (Markides 1983, p.123).

Two other variables, primary group relations and psychological well-being, were also used to test the hypothesis. The hypothesis was not supported in the Dowd and Bengtson study of the Ward study. Thus, the double jeopardy hypothesis predicting widening differentials with age between the minority and majority group persons finds mixed support in the empirical literature on blacks and Hispanics (Markides 1983, p.127), and probably on Asian and Native Americans. Yet most minority gerontologists use this thesis to argue for increased services for the minority elderly, just as they suspect the age-as-leveler and the model minority perspectives to be a justification by the majority for status quo which the minority gerontologists interpret to be insufficient services to the minority elderly. The remainder of this chapter reflects a double jeopardy perspective on the minority aged.

We saw in the previous chapters that as the elderly population increased, services to them and personnel to deliver these services increased. Much of the programs and positions for them became available with the funds provided through the Older Americans Act (OAA) of 1965, PL 89-73, (1) establishing the Administration on Aging (AoA) within the Department of Health, Education, and Welfare (HEW); (2) providing formula grants to states for community planning and services; and (3) providing project grants for public and private nonprofit agencies for research, development, or training. Another federal agency, the Institute on Aging, was created in 1974 primarily for research (Lockett 1983).

Over the years, OAA has been amended several times, furthering efforts to provide a comprehensive program of social services for older persons. A major revision came with the Older Americans Act Amendments of 1972, PL 92-258, which included a new Title VII, the national nutrition program for the elderly. The Older Americans Comprehensive Services Amendments of 1973, PL 93-29, (1) placed AoA in the Office of the Secretary of HEW, and (2) revised the Title III state grant programs. To participate in the new Title III program, each state was required to divide itself into planning and service areas (PSAs) and to designate an area agency on aging (AAA) to administer all local programs within the PSA.

The lack of minority participation in OAA programs and of minority staff on aging network agencies became a major concern of many groups and individuals. In

response, Congress enacted the Age Discrimination Act of 1975, PL 94-135, as part of amendments to OAA (1) establishing model project provisions requiring AoA Commissioner to give special consideration to project that provided needed services to minorities including limited-English-speaking elderly, and (2) mandating the Commission on Civil Rights to conduct an age discrimination study.

One of the findings from the study was that older members of minority groups were often victims of age as well as racial or ethnic discrimination. Furthermore, program administrators were not taking sufficient steps to take into account the multiple problems faced by many minority older persons and to increase their opportunities for obtaining needed services and benefits (U.S. Commission on Civil Rights 1977, pp.24, 26).

Other studies also reported similar findings. Bell *et al.* (1976) reviewed the literature on delivery of social services to older minority persons, and concluded that none of these groups' service needs were being met. The study identified several barriers to minority participation, including a lack of awareness of cultural diversity coupled with a generally negative program staff attitude towards minority older persons. Schneider (1979) examined outreach efforts in nutrition programs. This study documented the absence of older minorities in the nutrition programs and identified barriers to participation, including perceived racism and racial prejudice of program staff by older minority persons, the lack of clarity of the entitlement nature of the program, and inadequate access (transportation) to nutrition sites.

These studies and their findings generated greater complaints from minority communities and led to a series of hearings before the House Subcommittee on Select Education on the effect of OAA programs on older Americans. A considerable amount of public testimony was provided primarily from four major minority national organizations: National Caucus and Center on the Black Aged (NCBA), Asociacion National Pro Personas Mayores, National Pacific/Asian Resource Center on Aging, and National Indian Council on Aging. The hearings produced a substantial amount of allegations that minority elderly are not being served by OAA programs (U.S. Commission on Civil Rights 1982a, pp.9-11).

The Congress then passed the Comprehensive Older Americans Act Amendments of 1978, PL 95-478, which made extensive revisions to OAA: (1) consolidating Titles III, V, and VII under a new Title III, thereby combining social service, nutrition, and multipurpose senior center programs; (2) removing the 1975 model project provisions giving special consideration to minorities; (3) adding a new Title VI to promote social service delivery, including nutrition services, to American Indians, and (4) mandating two studies concerning the allegations of discrimination against minority elderly.

The 1978 Amendments authorized the Federal Council on Aging to undertake a thorough evaluation and study of OAA programs (Cuellar *et al.* 1982,

p.41). Based on this study, the U.S. House Select Committee on Aging (1980) presented a report, **Future Directions for Aging Policy: A Human Service Model**, to Congress. This report proposed "options" to seven questions which will guide future aging policy: (1) who should receive priority for senior services? (2) should a future service system for seniors be age-integrated or age-specific? (3) what kind of services should be involved? should the model employ a preventive or treatment orientation? (4) should we emphasize acute or long-term care? (5) what is the scope of services that should be available? should they be limited or comprehensive? (6) should policy making and service provision in our model be centralized or decentralized? (7) will the many resources needed for our human service system be found in the public or the private sector?

The 1978 Amendments also mandated the Commission on Civil Rights to investigate the validity of allegations of discrimination against minority elderly in OAA programs. Specifically, the law mandated the Commission to (a) undertake a comprehensive study of discrimination based on race or ethnic background in any federally-assisted programs and activities which affect older individuals; and to (b) identify with particularity any such federally-assisted program or activity in which evidence is found of individuals or organizations who are otherwise qualified being; on the basis of race or ethnic background, excluded from participation in, denied the benefits of, refused employment or contracts with, or subject to discrimination under, such program or activity.

Since the minority older population is largely an urban population, greater emphasis was placed on urban site selection, although both urban and rural locations were considered. Both large- and medium-sized cities were selected. In addition, every city chosen had an AAA office in that city, whether or not the PSA served by the AAA covered more than the city proper. Special attention was given to the representation of each of the four minority groups: blacks, Hispanics, Asian/Pacific Islander, and native Americans. The six cities chosen were Cleveland, Ohio; Bridgeport, Connecticut; Tucson, Arizona; Tulsa, Oklahoma; San Francisco, California; and Honolulu, Hawaii.

The Commission first collected demographic data for each city. During the field investigation, the Commission sought (1) to identify program characteristics that affect minority participation, and (2) to obtain information on staffing patterns of the AAA and its Title III-funded organizations; the AAA's identification of and selection criteria for Title III-funded organizations; the AAA's affirmative action activities and its methods of outreach to minorities; the extent of minority participation in program management, administration, and evaluation; and types of AAA monitoring and compliance activities.

Local program administrators, social service providers (AAA funded and non-AAA funded), representatives of community organizations, and AAA advisory council members in each community were interviewed and questioned on their perceptions of efforts to provide better services to the minority community.

Program administrators were asked to identify program priorities and the extent to which the concerns of older minorities entered into the determination of these priorities. They were also asked about attempts by the AAA directors and their Title III-funded organizations to identify differential and preferential needs of the minority elderly, and what efforts were being made to facilitate participation by minorities (U.S. Commission on Civil Rights 1982a, p.3).

This investigation found (a) that in almost every city the minority elderly were being underserved due to limited outreach programs, programs unresponsive to minority elderly needs and low participation in these programs, and (b) that although almost all of the AAAs had affirmative action plans, goals for hiring minority staff were unmet and corrective actions had not been initiated. Minorities were underrepresented in administrative and supervisory positions (U.S. Commission on Civil Rights (1982a; 1982b).

AoA in the mean time awarded several grants to investigate the alleged lack of minority participation in OAA programs such as Collen and Soto (1979) and Cuellar and Weeks (1980). The major finding of the latter, the San Diego study, was: the evidence supports the general hypothesis that minority elders are not receiving an equitable share of public benefits relative to their needs. "The definition of equity based on the concept of numerical proportionality is only one of several ways of viewing equity. Perhaps a more reasonable definition is that which is based on level of need. Thus, an equitable share means that people receive public benefits in proportion to their needs – those with greater needs receiving relatively more than those with fewer needs" (Cuellar and Weeks 1980, p.5). "Earlier equity studies conducted for AoA during the late 1970s concluded that the need for services among aged minorities is 2 to 3 and 1/2 times as great as for the nonminority elderly" (NCBA 1987, p.61). The greater need for services among minority elderly is due to the fact that, as shown in Table C5, percent of families below poverty level is higher among them.

It is the Civil Rights Commission Report and its findings, however, which have become cited most frequently as an, if not the, authoritative source of data to support the allegations of discrimination against minority elderly in OAA programs. One group, which has a vested interest in AAAs, the National Association of Area Agencies on Aging (N4A) attempted to refute the Commission Report and its conclusions. "N4A has great concern with the conclusions presented in the report as they are **not** substantiated by the report's own accompanying data. Based on a thorough review of the numbers cited in the report, N4A notes that the conclusions are consistently gross and inaccurate. In an effort to document this serious flaw, N4A calls attention to specific passages in the report which serve as but a few of the examples in which this is a problem [see Tables C1 - C4]. There are further concerns with the way: Data is interpreted, analyses are performed and AAAs are described. For these reasons, which will be elaborated below, N4A takes issue with the summary statements and concluding remarks stated in the Civil Rights Commission Report" (Mastalish 1982).

The Commission quickly responded. "The N4A conclusion about the report regarding interpretation of data involves the issue of data aggregation . . . which lump all minority groups into one "minority" grouping, a process which the Commission does not favor . . . In fact, misleading conclusions can be drawn from the table on AAAs' employment of minorities noted in N4A review . . . Aggregation of minority elderly participation also obscures results for individual groups . . . A major concern of the Commission's study was not only the numerical extent of minority employment, but also the job patterns for minorities . . . even where minorities were employed, they were generally not employed in managerial positions . . . We believe that the data in the report does substantiate the summary's findings" (Hope 1982).

Taeuber and Attah (1988) have recently shown that use of data aggregation or averaging is misleading in describing the older population. N4A's own later review of the "literature on minority service utilization clearly shows that older minorities have not received an adequate share of Title III services for which they are eligible. It also points out that minorities tend to be underrepresented in the network on aging not only as service recipients but as professional employees and service providers" (Wiggins 1986, p.6).

Despite the serious problems encountered by minority elderly, they continue to be underserved in OAA programs when measured against their need for services. Moreover, the situation seems to be deteriorating rather than improving (NCBA 1987, p.62). In fact, as shown in Table C6, the minority participation rate for Title III-B supportive services program has dropped from 21.9 percent in 1980 to 16.5 percent in 1985. A similar pattern exists for Title III-C nutrition program. The minority participation rate has fallen from 19 percent in 1980 to 16.4 percent in 1985.

When we consider only the black elderly, as shown in Table C7, nearly 300,000 fewer blacks received supportive services in 1985 than in 1980, falling from 13.9 percent in 1980 to 10.7 in 1985. The black participation rate for the nutrition program dipped from 11.2 percent in 1980 to 10.1 percent in 1985. What are the reasons for these declines of minority participation? NCBA (1987, pp.63-64) reviewed the literature, and they include the following:

1. Aged minorities frequently feel that OAA programs were not responsive to their needs and priorities.

2. Elderly minorities are often under-represented or not represented at all on advisory councils for the service delivery planning process.

3. Senior centers may be located in areas which are inconvenient or inaccessible for aged minorities.

4. Transportation can be a serious problem for obtaining necessary services, especially for low-income seniors without an automobile.

5. The fear of crime may deter elderly minorities from venturing out in public to receive necessary services.

6. Nutrition sites may not provide culturally appropriate meals.

7. Publicity about service programs tends to be limited, especially in languages other than English.

8. AAAs do not generally conduct vigorous outreach efforts to locate more older minorities.

9. The aging network has not been diligent in monitoring participation by elderly minorities.

10. Efforts to promote "volunteer" contributions at nutrition sites, especially if they are pursued in an overly aggressive fashion, can inhibit the minority low-income elderly from participating fully.

The above list is not meant to be exhaustive or mutually exclusive. It simply illustrates some barriers to minority participation in OAA and related programs. Not all these barriers may be observed at each and every agency, but one or more of these barriers are known to exist in all agencies. It is probably impossible to remove all barriers from all agencies. In fact, it would be very difficult to remove any of them. However, efforts to remove them should be made, and are being made. In the next chapter we will discuss some of these efforts.

CHAPTER IV

EFFORTS TO INCREASE MINORITY PARTICIPATION

In response to concerns expressed by minority groups, AoA implemented the Minority Participation Initiative and the Minority Training Initiative (Tolliver 1984; AoA 1985, p.13). For the former, AoA funded several projects including one at N4A (Rodkin 1986a; 1986b; Wiggins 1986). For the latter, AoA funded NCBA on behalf of itself and three other national minority aging organizations mentioned earlier for a Minority Management Internship project in 1981. This program focused attention on increasing the recruitment, training, and placement of minority individuals in the field of aging. A total of 66 individuals have been trained during the three-year (3/1/81 - 9/30/84) demonstration period, and 43 of them (65 percent) have been placed in permanent aging related employment (Tolliver 1984; NCBA 1985).

In 1986 AoA expanded this particular effort to other applicants. This chapter reports one of the 1986 projects funded by AoA to Grambling State University by AoA. Other projects are, unlike the NCBA model, training programs of students. Their emphasis therefore is a coursework, and their training is part of this coursework. The Grambling project is a replication of the NCBA model in that it was open only to those who (1) had graduated from colleges or universities, and (2) were available for full-time internship. We adopted this approach for several reasons:

1. Studies of the U.S. Commission on Civil Rights mentioned in the previous chapter implied a strong association, if not a causal relation, between the proportion of the minority staff at the management positions and the utilization rate of services by the minority elderly. Such a relationship was observed in Pennsylvania. Two counties with about equal proportion of the minority in the elderly population were compared. One (County A) had a very high level of minority participation in aging network services; the other (County B) had a very low level of participation. Almost all things were equal. What explained the difference? The proportion of minority on the staff. County A had a significantly higher proportion of minority staff than County B.

2. Therefore, it appears that increasing minority staff is one, if not the only, of the most effective way of increasing minority participation in aging programs and services. We in the academia have no control over who gets employed in the aging network agencies, and cannot influence them to hire more black professionals, at

least not directly. But there may be some indirect ways of doing so. Internship is such an indirect approach.

3. A host agency accepting a trainee is more likely to hire that trainee if he/she serves as a full-time "intern" and already has a college degree than if he/she is a college student student doing a "practicum" as partial requirement for a degree or even a course. If nothing else, the agency will have more time to assess the trainee, without being obligated to pay him/her, if he/she is an intern rather than a practicum student. NCBA required a graduate (master's) degree for its internship, because it recruited national or regional organizations to be host agencies who may be able to pay the intern, if employed after completion of the internship, at an appropriate level. Our project, on the other hand, is limited to only one portion of Louisiana. Our host agencies are small local councils; their work is not highly sophisticated, and their salary levels are low (they are generally low nationwide, as seen in an earlier chapter). A baccalaureate degree was deemed sufficient.

4. In both the Ketron (1981) and Peterson (1985) studies, the previous work experience was found to be the most significant determinant of employment. This is OK for people whose education was interrupted, for those who worked for a year or more, started or resumed college education, and earned a degree. The work experience requirement creates a problem for others who had been a "regular" student all the way. How can you have a work experience, when you just graduated from college? Many minority graduates, especially those from HBCUs, claim that such a requirement is often conveniently "waivered" for white applicants. Empirical evidence for such a claim is not available, but it is reasonable to assume that if a dilemma of degree plus work experience exists, blacks encounter such a dilemma more frequently than whites. In any case, a full-time paid internship is a way of dealing with this dilemma; it provides the intern with an opportunity to have that work experience.

RECRUITMENT AND SELECTION OF HOST AGENCIES

Prior to submission of our proposal to AoA we visited several agencies in Northeast Louisiana; explained the purpose, objectives, and tasks of the proposed project; and encouraged them to serve as host agencies. One of them, while "terribly understaffed" and therefore "could use an intern," did not have any "reasonable assurance to pick up the intern at the end of the project" and declined to participate in the project. Others expressed their profound interest in the project but "saw absolutely no chance of employing the intern" after the project is over and decided not to participate.

Following these self-selections, three host agencies were selected (see Appendix D1). They are Ouachita Council on Aging (OCOA), North Delta Area Agency on Aging (AAA), and Division of Children, Youth, and Family Services (DCYFS). OCOA is a single-parish AAA. As such it is both a service provider for Ouachita parish and a planning agency for itself. North Delta is a multi-parish AAA

consisting of five parish councils on aging (COAs): East Carroll, Franklin, Jackson, Richland, and Union COAs. DCYFS is part of the Office of Human Development (OHD), which is part of the state Department of Health and Human Resources (DHHR). DCYFS is divided in eight regions including one in Monroe. The Monroe Regional Office is divided into two districts: East and West, each with six parish offices.

The primary duties of DCYFS include child protective services (CPS). In 1975 when the adult protective service law was enacted, the mandate of adult protective services (APS) was given to DCYFS. Since this mandate was given with no extra funds or staff, CPS workers were also made responsible for APS. Because CPS workers were already overworked with an extremely high caseloads, APS duties tended to be ignored. APS existed only *de jure*, it was almost nonexistent *de facto*. The APS law was amended in 1985 (Revised Statute 14:403). The 1985 amendments included three additional items again without any additional funds or staff resulting in even higher caseloads for CPS workers: (1) mandatory reporting of elderly abuse, (2) abuse to be reported must include self-abuse, and (3) immunity from civil liability for reporting abuses. CPS workers are also APS workers.

The Monroe Regional Office of DCYFS requested and got two interns, one for East District to be located at the West Carroll parish office and another for West District to be located at Union parish office. OCOA requested and got one intern. North Delta requested five interns, but got four because the project was funded for only seven interns. One was assigned to East Carroll COA, another to Franklin COA, the third to Jackson COA, and the fourth to North Delta AAA office as well as Richland and Union COAs.

RECRUITMENT AND SELECTION OF INTERNS

One rationale for this project was minority college graduates needed one year work experience to be employed. Therefore, the internship was set for a 12-month period. In determining the stipend for each intern, we requested $15,000 in the proposal. Although the *average* salary of teachers in Louisiana was $20,460 as discussed in Chapter II, the *beginning* salary of teachers and the Human Service Worker I in DHHR was $15,000 on the average. We considered these two positions, as they both require a baccalaureate degree, and are comparable to our interns. Hence, the recommendation for $15,000. However, during the budget negotiation prior to actual award of the grant, this amount was adjusted downward to $12,000. (In later RFPs, AoA set the upper limit of stipend to $1,000 a month.)

The official notification of grant award came in mid-July 1986. We had less than two months to recruit interns, if we wanted to begin our internship in September as planned. This limited our recruitment efforts to local areas. Although we mailed our announcement to the newsletter editors of the national gerontology organizations including minority aging groups and asked for their help in the recruitment, we did not and could not expect any significant or serious out-of-state

applications. We issued a news-release, and the project was featured in local newspapers. We also asked host agencies help us advertise. Some of them listed the positions in the parish offices of the state Employment Commission.

A total of 18 applications was received by mid-August. Seven of them heard about the project by word-of-mouth, and the remaining five applied through the Employment Commission. The former type of applications (word-of-mouth) were expected, but the utilization of the Employment Commission was a pleasant surprise. At the time of the proposal writing, it was not in our anticipation. In Northeast Louisiana "minority" almost synonymous with "black," because we have very few Hispanics, Native Americans, or Asian Americans in this area. Thus, all 18 applicants were blacks.

Only two were male applicants. This is not surprising based on our prior experience. Out of 908 employees (74 percent white, 26 percent black) from aging network agencies in 25 counties around Livingstone College in North Carolina who participated in the college's training program from 1982 through 1986, only 54 or 6 percent were males (Cho 1986). Here at Grambling, we wanted to appoint at least one male intern, but failed to do so. One was still in school, a summer session. He was not sure he could complete his degree requirement by the end of August. Another, residing in Grambling, could not accept our offer, because he did not want to relocate to any of the three internship sites we suggested which were all more than 80 miles from his home in Grambling. The stipend was low ($1,000 a month), and we could not *guarantee* his employment upon completion of the internship. The agency budget may be cut. Even if the agency had the budget, he may not be a type of worker the agency needs or wants to hire.

A host agency representative (director or his/her designee) and the Project Director conducted a joint interview of the applicant or applicants (some agencies had only one applicant) at the agency. All host agencies required the interns to have an automobile available for them for their use with a valid driver's license. In addition, DCYFS had two more requirements. All state volunteers as well as employees are required to have (a) an appropriate driver's license (no more than three traffic violations), and (b) work-related liability insurance (regular, personal liability insurance is not sufficient). Interns are considered "volunteers," as they were not paid by the state. The state is still responsible for their actions affecting citizens. Selection and appointment of interns were made with mutual agreements. Seven interns so selected and their host agencies, agency supervisors, and project liaisons are listed in the Appendix D2.

AGREEMENT AND UNDERSTANDING

To ensure a successful implementation and completion and to avoid any misinterpretation or misunderstanding between the project and the host agency, and between the project and the intern, a contract was drafted for each case. However, Mrs. Coody, Administrator of the DHHR/OHD/DCYFS Monroe Regional

Office, informed us that all "contracts" can be signed only in the head office in Baton Rouge. Regional Administrators are not authorized to enter into any "contract." Thus, it was changed to LETTER OF AGREEMENT (Appendix D3). It was used for the other two host agencies as well, Ouachita Council on Aging and North Delta Area Agency on Aging, with minor modifications involving the name of the agency, the number of interns to be placed, etc.

The contract with interns to be placed in DCYFS was changed to LETTER OF UNDERSTANDING (Appendix D4). It was also used for interns in two other host agencies as well, with minor modifications concerning the agency name, starting date, etc. The internship was originally planned to begin on 9/2/86 (9/1/86 was a holiday). However, because of the time constraint on recruitment, only four interns began on that day. The remaining three began on 10/1/86.

INTERNSHIP

The internship was planned to begin with an Orientation Seminar on the first day, 9/2/86. However, because of the split in the starting dates and to accommodate both groups of interns, the seminar was conducted on Monday, 9/29/86, at the Conference Room of the Grambling State University School of Social Work with welcome by Dr. Lamore Carter, Vice President for Academic Affairs and Dr. William Pollard, Dean of the School. Greetings were followed by introductions to host agency programs and services by directors of three host agencies.

The afternoon training sessions were for interns only. These sessions were led by the project staff and covered the following topics: (1) public policy, laws, rules and regulations on aging, and their relations to the project – Dr. Pill Jay Cho, (2) intergovernmental relations in Northeast Louisiana, and their relations to the project – Mr. Terry McPhearson, (3) monthly conferences, and monthly seminars – Dr. Larcy McCarley, Dr. Joanne Rhone, and Mrs. Jennette Russell, and (4) stipend checks and related matters – Mrs. Phillis Burton.

As per LETTER OF AGREEMENT mentioned earlier, host agencies prepared "job" descriptions for interns. The Monroe Regional Office of DHHR/OHD/DCYFS submitted the following:

1. In-take process screening

Obtain identifying information; determine if the report meets requirements of state law; determine, with close supervision, the current status of the adult to evaluate extent of danger/risk; prepare compliant form.

2. Investigative process

Conduct investigations of allegations of abuse and/or neglect of adults in accordance with agency policy. Assess, under close supervision, the degree of severity of harm or danger and determine the immediacy of response.

3. Services to the adult

Evaluate immediate service needs. Advise supervisor of immediate service needs. Under close supervision, provide needed services or refer client to community resources.

4. Services to family

Provide, under close supervision, those immediate services required during the investigative process, obtain all appropriate information from family members and collaterals to make a determination of validity or invalidity and make appropriate ongoing service referrals.

5. Court involvement

Prepare and submit appropriate reports/affidavits to the court in compliance with state laws, regulating the care and treatment of adult individuals who have been abused and/or neglected; who are in need of alternate custody and/or placement; or, who are interdicted as a result of court review.

6. Case maintenance

Maintain case files and prepare and submit reports as required by agency policy or state law.

7. Ongoing services

Provide and/or arrange for ongoing services in order to prevent removal from the home and/or prevent additional abuse and/or neglect, when indicated.

8. Other duties

Attend and participate in formalized training programs and seminars relative to adult abuse and/or neglect investigations or services to adult victims of abuse and/or neglect. Attend all required in-service training. Adhere to DHHR/OHD rules and regulations. Accept and perform duties not otherwise specified, but necessary for the smooth operation of the office. Prepare for and participate in supervisory conferences (Agency supervisor and Project liaison).

North Delta AAA submitted the following:

A. For intern to be assigned to North Delta AAA, Richland and Union COAs

1. Perform duties of a case manager.

2. Assist the aging planner in compiling a 4-year plan.

3. Assist in preparation of monthly financial reports, posting of accounting records and bank reconciliation.

4. Assist in financial assessments of parish COAs.

5. Assist in review of budgets and contracts.

6. Participate in the Nursing Home Ombudsman Program.

7. Participate in adult education program (teach the elderly to read and write) at Richland COA office.

8. Conduct outreach visits in Richland and Union parishes.

9. Evaluate participants receiving home delivered meals in Union parish.

10. Visit and obtain data from elderly citizens requesting services in Union parish.

B. For intern to be assigned to East Carrol COA

Train in all phases of the organization pertaining to the aging network including the following: Title III support services – case management, information and referral, outreach, transportation, escort, homemaker, visiting/telephone reassurance, advocacy, health facilitation/physical fitness, and recreation; congregate nutrition services; home delivered meals; senior center programs; other appropriate duties.

C. For intern to be assigned to Franklin COA

1. Learning each job and working with each employee in the COA operations.

2. Interview elders for project, conducting assessment and identification of available resources and service needs, maintain a current resource file of programs available for elderly.

3. Serve as advocate to enable elderly to receive needed social and health services.

4. Maintain case files and reports documenting activities, including statistical summaries, outreach, and phone calls.

5. Serve as liaison to various community organization, referring clients and insuring cooperative efforts in the provision of needed services.

6. Help Senior Center Coordinator in scheduling activities, classes, and nutrition education at the centers and for home-delivered meal participants.

7. Responsible for learning all reporting systems of each program which will enable the intern to complete monthly reports.

8. Learning experiences, maintaining and organizing in the office files, assures that proper security measures are followed concerning confidential files and materials.

9. Assist the director in planning and analyzing specific office problems affecting operations, advise the director of the current situation and problems caused by the situation, and make recommendations of possible solutions.

10. Assist bookkeeper with posting books, keeping payroll ledger, making payroll, daily attendance sheets and transferring to cumulative leave records, separating bills into correct programs and writing out checks, balancing bank statements, and monthly financial reports.

D. For intern assigned to Jackson COA

After an orientation to all activities including Title XX and administrative procedures from budget to reports, training will cover congregate and home-delivered meals programs, senior center activities including development of ideas for Older Americans Month, transportation, and others.

Ouachita COA submitted one similar to that by Jackson COA. These "job" descriptions were not intended to be inflexible rules for training interns. They are simply some indications of what interns will be learning, and what they are expected to be doing at the host agencies. Their activities at host agencies were to be supplemented, monitored, and evaluated through monthly conferences and monthly seminars.

MONTHLY CONFERENCES AND SEMINARS

Both host agencies and interns have been carefully chosen, and we did not expect any major problems. However, there was no guarantee for success. We believed that the best "solution" was the early detection and prevention. Monthly conferences at host agencies provided agency supervisors as well as interns with opportunities to ask questions, to clarify issues, and to consult with project liaisons for other matters related to satisfactory progress of the intern and successful completion of the project. After each such conference, project liaisons made their reports to the project director (see Appendix D5 for an example). Monthly seminars at the project office provided interns with additional opportunities to consult with the Project Director and liaisons, to pick up their stipend checks, and to receive supplemental training.

Monthly seminars were divided into morning and afternoon sessions. Morning sessions were training in areas of concern to the host agencies or the interns lectured by project staff and guest speakers. These lectures included the following: interviewing and recording; theories of organization and management, personnel management; program management, planning, monitoring, evaluation, accountability, and resource development; stress management in services to the elderly; Medicare and Medicaid; general methods of social work practice with special emphasis on services to the elderly; and services to the Alzheimer's patients and

their caretakers. Afternoon sessions were individual conferences to deal with problems, if any, or to discuss interns' final reports.

Monthly conferences and monthly seminars meant two meetings each month, one at the agency and another at the project office. This was too frequent. Travel expenses for the two meetings were too expensive – about $500 each month. After the second month, therefore, they were changed to bi-monthly meeting only once a month. Even with this change, the travel budget in the grant ran out before the internship period was over. Fortunately, the University provided the project with the necessary travel expenses.

EVALUATION AND ACHIEVEMENT

Conferences and seminars accomplished their primary objectives, early detection and prevention. There were only two cases of minor misunderstandings between an intern and her supervisor. The project director was able to intervene, and the matters were resolved to the satisfaction of both parties. Except for these two minor incidents, agency supervisors and directors were pleased with their interns, and interns all liked their placements and enjoyed their work assignments.

Although all parties – interns, agency supervisors and directors, and project staff – have been satisfied with the progress, a structured evaluation was conducted by means of a form, Intern Performance Evaluation Form (see Appendix D6), which was developed by the project staff. It was conducted in March 1987 (for those began in September 1986) and in April 1987 (for those who began in October 1986) at the host agency by the project liaison with the intern and her supervisor. All three signed the completed form. Every form showed that all items were checked either 4 (good) or 5 (excellent).

At the end of the internship, each intern submitted a final report. The project director had been advising each intern on the report at the Bi-monthly Seminars, and interns had been working on it all along. The final report was not meant to be a formal thesis. But we did not want each intern to just say "I receive a good training," "I learned a lot," or "it was a nice experience" at the end of the project. The final report helped interns focus on one of many things they learned at their agencies as per the "job" descriptions discussed earlier. Interns were encouraged to be innovative and flexible about the report.

Submitted reports ranged from a very formal thesis to a very informal paper. Terri Green at Ouachita Council on Aging wrote a thesis on "Minority Participation in Aging Program," which she later revised and enlarged for her Master of Social Work degree. Jacqueline Pace at Jackson Council on Aging initiated a 40-page quarterly newsletter, **The Senior Informer**, for the elderly citizens of Jackson parish. In connection with the newsletter, she sponsored a poetry writing contest for senior citizens of Jackson parish aged 60 and over. She was able to obtain gift certificates for

the first and second place winners from local department stores, Wal-Mart and Beall-Ladymon. The winning poems are:

A Tribute to Teachers
(First Place)

Teachers are talented;
Excellence is their trade as they
Answer the many questions
Children everywhere have made.
Helping hands are ever ready,
Eyes and ears are open wide
Ready to give assistance as
Students the world in stride.

Irma Colvin

A Blessing
(Second Place)

Heavenly Father,

We thank Thee for taking care of us all night long,
And for waking us up this morning in our right minds,
And starting us off on another day's journey.
We thank Thee that every way of life is well with us
as it is.

Bless the sick wherever they may be,
Bless all those under the sounds of my voice,
Bless this food to the nourishment of our bodies.
Bless the hands that prepared it.

All this we ask for Jesus' sake. Amen.

Cleveland Birdo

Opportunity and Opposition
(Third Place)

There is opportunity aplenty
In the studying of God's word;
It is helpful and a blessing
When it's read and even heard.
God has left us a great roadmap
That will lead and guide our way.
God's word should be studied
Each and every day.

Each one has the opportunity
To study God's word for himself,
And to live his life according
To the Master's Message He has left.

In this life of opposition
Where Satan always raises his ugly head,
God's plan for us to follow
In the scriptures we have read;
Study to show thou self approved
Was Paul's message long ago.
When we study we have knowledge
Of what God wants us to know.

Opposition awaits us as we travel
Life's rugged road
But the opportunity to follow Jesus
Is made clear and will afford
Eternal life for all who seek Him
In this life of stress and woe.
Jesus, our loving Savior, keep us
And abides with us
Day by day forever more.

Don't let Satan's opposition decrease
Your power to live with Christ.
Study God's word daily,
And you'll find that they suffice.
We are told to follow Jesus
And to all that's good advice.

Nomie Farley

In January 1987 one of the seven interns, Jacqueline Pace, who was doing her internship at Jackson Council on Aging, was offered a position at Lincoln Council on Aging. The long-range goal of this project was increased minority participation in aging network programs and services by increasing minority staff in these agencies. An immediate objective was to find employment of seven interns in host agencies or other agencies delivering services to the elderly. For one of the seven interns, this objective was achieved *before* the internship expired. This is quite a achievement both for the intern as an individual and the project as a whole. By mutual agreement of the agency and the project, Marion Brown was chosen to replace Jacqueline Pace.

In March 1987, another intern, Anna Alford at the DHHR/OHD Monroe Regional Office East District, was employed by the host agency to be stationed at Richland parish office. The unexpired term of her internship was five months, and her supervisor, Mrs. Melba Sandifer did not feel she could offer any meaningful training to a new person. Thus, it was mutually decided not to appoint a replacement of Ms. Alford. In late August 1987, Sarah Dunn at the DHHR/OHD Monroe Regional Office West District was also offered employment by the host agency. However, she was going to marry in September 1987 and to move to Seattle, Washington with her husband.

Pam Green at North Delta Area Agency on Aging passed the Ombudsman exam, and was certified as an Ombudsman by the Governor's Office of Elderly Affairs (the state unit on aging). She was employed by one of the group homes for the elderly in the area in September 1987 upon the successful completion of her internship.

Brenda Grover at East Carroll Council on Aging has a degree in biology. As she worked with the elderly clients, she became concerned about their health. She applied for admission to the Armed Services University Medical School in Rockville, Maryland. She was accepted for admission, and was ready to be a medical student in September 1987 upon completion of her internship. Unfortunately, she became ill and was not able to go. She is now recovering from her illness, and seeking admission to the Louisiana State University Medical School in New Orleans. She wished to be a doctor someday working for the health and well-being of the elderly. Mrs. Mary Knight, Director of the East Carroll COA, wishes to retain Ms. Grover as an employee, but she could not do so because of the recent state budget cuts.

Mr. Joseph Nastasi, Director of Ouachita COA, also wanted to employ Terri Green but could not for the same reason as Mrs. Knight's. Ms. Green became a full-time graduate student at the Grambling State University. She received her Master of Social Work degree (with concentration in gerontology) in May 1988. Her thesis was the final report of her internship, as mentioned earlier. She is now in California with her parents. We believe that Sarah Dunn in Washington and Terri Green in California will soon find employment in agencies serving the elderly.

Mrs. Carolyn Ezell, Director of Franklin COA, also wanted to employ Antoinnette Douglas but could not for the same reason. But she believes she can find a job for Ms. Douglas in a hospital. Ms. Douglas has a degree in accounting, and now has a work experience in aging. Many area hospitals have a large number of Medicare and Medicaid, and other elderly patients, and Mrs. Ezell thinks Ms. Douglas is marketable in accounting offices or social service departments of hospitals. Marion Brown, who replaced Jacqueline Pace at Jackson COA is now a full-time graduate student at the Grambling State University School of Social Work with concentration in gerontology.

In conclusion, we believe that the project is a success: four of the seven interns are employed or offered employment prior to or upon completion of their internships. Two are likely to be employed soon, and one is going to a medical school for a geriatric training and career. Before closing, it should be mentioned that there was a Certificate Award Ceremony held on Monday August 31, 1987 in the Conference Room of the Grambling State University School of Social Work with all eight interns (seven plus one replacement) attending. There was also a Banquet in honor of interns placed in North Delta AAA and its affiliates on Friday, September 25, 1987 with all five (four plus one replacement) attending. The speaker at the Banquet was Mrs. Sandra Adams, Director of the Governor's Office of Elderly Affairs. Each supervisor was asked to say something about her intern in less than five minutes. One had her remarks in writing, and we asked to give us a copy so that they can be reproduced here. They give a pretty good idea as to what Brenda and other interns in COAs have done and learned.

BRENDA GROVER: INTERN AT EAST CARROLL COUNCIL ON AGING
by Mrs. Mary Knight, Director

I would like to introduce the intern from East Carroll Council on Aging, Brenda Grover. Brenda is a 1983 graduate from Mississippi Valley State University in Itta Bena, Mississippi.

Brenda's association with the Council began on October 1, 1986. From her inception she became involved in all aspects of the Council.

One of her first task was to learn the history of the Council, its goals, objectives, employees and their job responsibilities, board of directors, etc.

From there, Brenda visited some of the participants homes, learning their needs as well as their likes and dislikes.

She became familiar with all III-B reports, often helping to complete them. She became familiar with our total nutrition program having actually worked in all areas of C-I and C-II.

Brenda and I conducted a "needs assessment survey" from among our program participants; prescreening and screening criteria were used.

She was involved in our architectural check list at all sites, gathering materials to help make our sites handicap accessible.

Brenda and I worked diligently on a transportation proposal for a 16-(b)(2) vehicle. She and I traveled to Baton Rouge and met with Rodney Jenkins in learning how to prepare the proposal. She also assisted me in compiling our Title III proposal.

We attended a "personnel workshop" and together updated our personnel policy. We also put together an East Carroll Council on Aging pamphlet listing pertinent data of the Council. Brenda aided in compiling the data as well as putting the pamphlet together.

Brenda attended a workshop on "cost allocation" that aided her in learning to prepare a budget. She also worked with our bookkeeper to learn how the books are set up and maintained.

Brenda often assisted in obtaining guest speakers for our "calendar of events" each month and always prepared the calendar exceptionally well.

One of her greatest accomplishments was the execution of a fire evacuation plan of each of our three sites. Included in the plan were evacuation procedures for the elderly as well as stations (with fire extinguishers) to be operated by employees.

Brenda was excellent help with the Council's "special event programs" such as Easter, Thanksgiving, Christmas, Spring Fling, and our most recent program "Bells Across America." She added much to their success.

To conclude, Brenda became familiar with all the programs of the Council. I feel she now has a better understanding of the running of a Council on Aging.

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Table A1
U.S. Population, Median Age (M), and
Life Expectancy at Birth (e): 1880-1980

Year	Total	55+		60+	
1880	50,155,783	4,099,112	(8.2)	2,827,678	(5.6%)
1890	62,622,250	5,547,658	(8.9)	3,875,322	(6.2%)
1900	75,994,575	7,083,033	(9.3)	4,871,861	(6.4%)
1910	91,972,266	9,003,625	(9.8)	6,216,674	(6.8%)
1920	105,710,620	11,464,887	(10.8)	7,915,763	(7.5%)
1930	122,775,046	15,000,733	(12.2)	10,355,056	(8.4%)
1940	131,669,275	19,600,519	(14.9)	13,747,654	(10.4%)
1950	150,216,110	25,430,120	(16.9)	18,267,605	(12.2%)
1960	179,325,657	31,915,078	(17.8)	23,319,134	(13.0%)
1970	203,211,926	38,654,287	(19.0)	28,681,259	(14.1%)
1980	226,545,805	47,252,302	(20.9)	35,637,048	(15.7%)

Year	65+		70+		75+	
1880	1,723,459	(3.4%)	997,583	(2.0%)	502,141	(1.0%)
1890	2,417,288	(3.9%)	1,407,178	(2.2%)	705,427	(1.1%)
1900	3,080,498	(4.1%)	1,777,572	(2.3%)	893,731	(1.2%)
1910	3,949,524	(4.3%)	2,270,021	(2.5%)	1,156,293	(1.3%)
1920	4,933,215	(4.7%)	2,864,740	(2.7%)	1,469,704	(1.4%)
1930	6,603,805	(5.4%)	3,833,200	(3.1%)	1,883,196	(1.5%)
1940	9,019,314	(6.8%)	5,212,657	(3.9%)	2,643,125	(2.0%)
1950	12,256,850	(8.2%)	7,259,060	(4.8%)	3,852,395	(2.6%)
1960	16,207,237	(9.0%)	10,020,474	(5.6%)	5,359,338	(3.0%)
1970	20,064,475	(9.9%)	13,072,850	(6.4%)	7,629,019	(3.8%)
1980	25,549,427	(11.3%)	16,766,946	(7.4%)	9,968,822	(4.4%)

Year	80+		85+		90+	95+
1880	221,076	(0.4%)	74,714	(0.2%)	24,879	8,779
1890	312,365	(0.5%)	108,514	(0.2%)	33,274	9,629
1900	373,874	(0.5%)	122,362	(0.2%)	33,762	9,770
1910	488,991	(0.5%)	167,237	(0.2%)	44,419	10,946
1920	613,144	(0.6%)	210,365	(0.2%)	53,862	13,846
1930	776,806	(0.6%)	242,130	(0.2%)	66,661	14,997
1940	1,139,143	(0.9%)	364,752	(0.3%)	87,740	18,142
1950	1,702,020	(1.1%)	577,450	(0.4%)	147,845	29,150
1960	2,381,991	(1.3%)	863,785	(0.5%)	215,204	44,551
1970	3,794,185	(1.9%)	1,509,901	(0.7%)	492,754	179,517
1980	5,175,100	(2.3%)	2,240,067	(1.0%)	719,865	163,273

(continued)

Table A1
(continued)

Year	100+	M	e
1880	4,016	20.9	-
1890	3,981	22.0	-
1900	3,504	22.9	47.3
1910	3,555	24.1	50.0
1920	4,267	25.3	54.1
1930	3,964	26.5	59.7
1940	3,679	29.0	62.9
1950	4,475	30.1	68.2
1960	10,369	29.5	69.2
1970	106,441	28.1	70.8
1980	32,194	30.0	73.7

Source:
U.S. Bureau of the Census (1983a, p.1-26/Table 42).

Table A2
U.S. Population, and Median Age (M)
1980 - 1986
(Numbers in thousands; includes Armed Forces)

Year	Total	55+		65+	
1980	226,546	47,250	(20.9)	25,547	(11.3)
1981	229,637	48,192	(21.0)	26,236	(11.4)
1982	231,996	48,940	(21.1)	26,827	(11.6)
1983	234,284	49,711	(21.2)	27,478	(11.7)
1984	236,477	50,289	(21.3)	27,973	(11.8)
1985	238,741	50,871	(21.3)	28,536	(12.0)
1986	241,078	51,402	(21.3)	29,173	(12.1)

Year	75+		M
1980	9,969	(4.4)	30.0
1981	10,323	(4.5)	30.3
1982	10,630	(4.6)	30.6
1983	10,934	(4.7)	30.9
1984	11,234	(4.8)	31.1
1985	11,534	(4.8)	31.4
1986	11,847	(4.9)	31.7

Source:
U.S. Bureau of the Census (1987, p.20).

Table A3
Actual and Projected Growth of the Older Population
1900 - 2050
(Numbers in thousands)

Year	Total	55+		65+	
1900	76,303	7,093	(9.3)	3,084	(4.0)
1910	91,972	9,004	(9.8)	3,950	(4.3)
1920	105,711	11,465	(10.8)	4,933	(4.7)
1930	122,775	15,031	(12.2)	6,634	(5.4)
1940	131,669	19,591	(14.9)	9,019	(6.8)
1950	150,697	25,565	(17.0)	12,270	(8.1)
1960	179,323	32,132	(17.9)	16,560	(9.2)
1970	203,302	38,588	(19.0)	19,980	(9.8)
1980	226,505	47,244	(20.9)	25,544	(11.3)
1990	249,731	52,889	(21.2)	31,799	(12.7)
2000	267,990	58,815	(21.9)	35,036	(13.1)
2010	283,141	74,097	(26.2)	39,269	(13.9)
2020	296,339	91,629	(30.9)	51,386	(17.4)
2030	304,339	98,310	(32.3)	64,345	(21.1)
2040	307,952	101,307	(32.9)	66,643	(21.6)
2050	308,856	104,337	(33.8)	67,061	(21.7)

Year	75+		85+	
1900	895	(1.2)	123	(0.2)
1910	1,156	(1.3)	167	(0.2)
1920	1,469	(1.4)	210	(0.2)
1930	1,913	(1.6)	272	(0.2)
1940	2,643	(2.0)	365	(0.3)
1950	3,855	(2.6)	577	(0.4)
1960	5,562	(3.1)	929	(0.5)
1970	7,533	(3.7)	1,409	(0.7)
1980	9,967	(4.4)	2,240	(1.0)
1990	13,745	(5.5)	3,461	(1.4)
2000	17,343	(6.5)	5,136	(1.9)
2010	18,990	(6.7)	6,818	(2.4)
2020	21,617	(7.3)	7,337	(2.5)
2030	29,929	(9.8)	8,801	(2.9)
2040	37,475	(12.2)	12,946	(4.2)
2050	37,039	(12.0)	16,063	(5.2)

Adapted and rearranged from:
U.S. Senate Special Committee on Aging (1984, p.5).
See also U.S. Bureau of the Census (1982).

Table A4
Top Ten Chronic Conditions for Elderly
(Rates per 1,000 Persons), and
Percent of the Elderly in the Community with
ADL Limitations

	1981		1982	
Conditions	45-64	65+	45-64	65+
1. Arthritis	246.5	464.7	276.2	495.8
2. Hypertension	243.7	378.6	245.7	390.4
3. Hearing Impairment	142.9	283.8	142.7	299.7
4. Heart Conditions	122.7	277.0	136.8	256.8
5. Chronic Sinusitis	177.5	183.6	179.1	151.7
6. Visual Impairment	55.2	136.6	53.4	101.1
7. Orthopedic Impairment	117.5	128.2	139.0	168.5
8. Arteriosclerosis	21.3	97.0	21.5	73.6
9. Diabetes	56.9	93.4	57.6	88.9
10.Varicose Veins	50.1	83.2	64.1	77.7

	1982	
ADL	65+	85+
IADL Only	6.0	10.2
Mildly Disabled	6.6	17.4
Disabled	2.8	7.8
Severely Disabled	3.5	10.4
Total	18.9	45.8

Sources:
U.S. Senate Special Committee on Aging (1984, p.58; 1986, pp.87-88).

ADL: Activity of Daily Living
IADL: Instrumental ADL - managing money, shopping, light housework, meal preparation, making a phone call, and taking medication.

Mildly Disabled: ADL score 1-2
Disabled: ADL score 3-4
Severely Disabled: ADL score 5-6

Table A5
Median Family Income, Elderly and Nonelderly Families
1965 - 1984

	Actual Dollars			1984 Dollars	
Year	Nonelderly	Elderly	CPI	Nonelderly	Elderly
1965	$ 7,537	$ 3,460	94.5	$24,822	$11,396
1966	8,146	3,645	97.2	26,083	11,671
1967	8,753	3,928	100.0	27,242	12,225
1968	9,511	4,592	104.2	28,408	13,715
1969	10,438	4,803	109.8	29,587	13,614
1970	10,879	5,053	116.3	29,113	13,522
1971	11,406	5,453	121.3	29,266	13,991
1972	12,717	5,968	125.3	31,587	14,824
1973	13,496	6,426	133.1	31,558	15,027
1974	14,380	7,505	147.7	30,301	15,814
1975	15,331	8,057	161.2	29,599	15,555
1976	16,624	8,721	170.5	30,345	15,919
1977	17,960	9,110	181.5	30,798	15,622
1978	19,764	10,141	195.4	31,480	16,153
1979	22,175	11,318	217.4	31,746	16,203
1980	23,392	12,881	246.8	29,499	16,244
1981	25,138	14,335	272.4	28,721	16,378
1982	26,003	16,118	289.1	27,993	17,351
1983	27,243	16,862	298.4	28,414	17,587
1984	29,292	18,236	311.1	29,292	18,236

Sources:
U.S. Senate Special Committee on Aging (1984, p.31; 1986, pp. 41-44,57)

Elderly families: Families headed by persons 65 or older
Nonelderly families: Families headed by persons 25-64 years old

Table A6
Poverty Rates for Nonaged (18-64) and Aged (65)
1959 - 1984

Year	Nonaged	Aged	Nonaged	Aged	Nonaged	Aged
1959	17.4	35.2				
1966	10.6	28.5				
1967	10.2	29.5				
1968	9.1	25.0				
1969	8.8	25.3				
1970	9.2	24.5				
1971	9.4	21.6				
1972	9.0	18.6				
1973	8.5	16.3				
1974	8.5	14.6				
1975	9.4	15.3				
1976	9.2	15.0				
1977	9.0	14.1				
1978	8.9	14.0				
1979	9.1	15.2				
1980	10.3	15.7				
1981	11.3	15.3				
1982	12.3	14.6	7.5a	9.1a		
1983	12.1	14.2				
1984	11.7	12.4	4.5a	8.8a	9.6b	16.7b

Sources:
U.S. Senate Special Committee on Aging (1984, p.38; 1986, pp.43,55)

a: Between 100 and 125 percent poverty
b: Between 100 and 150 percent poverty

Nonaged: 18-64
Aged: 65+

Table A7
Source of Income as a Percentage of Income
1968 - 1983

Year	SS/RR	Asset	PA	Pensions	Earnings
Families with a head 65 and older					
1968	22.9	14.6	1.3	12.3	48.2
1970	25.0	14.5	1.4	12.5	46.6
1972	28.1	14.0	1.1	12.5	44.2
1974	31.1	15.4	1.3	13.5	38.8
1976	32.3	15.6	1.4	14.5	36.1
1978	32.2	15.7	1.2	13.8	37.1
1980	32.4	19.4	1.1	15.6	31.4
1981	33.0	21.7	1.0	14.9	29.5
1982	33.1	21.4	0.8	14.8	29.9
1983	34.3	20.9	0.8	16.0	28.0
Unrelated individuals 65 and older					
1968	34.2	26.5	4.1	14.4	20.8
1970	37.3	24.1	4.1	15.4	19.1
1972	41.7	24.2	3.2	14.3	19.1
1974	44.9	21.7	3.7	16.2	13.6
1976	46.9	20.9	3.0	15.7	13.4
1978	45.9	22.7	2.7	16.9	11.8
1980	47.4	24.4	2.5	14.6	11.2
1981	45.9	26.6	1.9	14.1	11.5
1982	45.3	28.7	1.8	14.1	10.1
1983	44.0	28.7	1.9	15.5	9.8

Source:
U.S. Senate Special Committee on Aging (1986, p.62)

SS/RR: Social Security and Railroad Retirement
Asset: Asset Income
PA: Supplemental Security Income (SSI) and other public aids

Table A8
Federal Outlays Benefiting The Elderly
Percent of Total by Program
1982 - 1985

Programs	1982	1985
Social Security	57	55
Medicare	22	23
Other retirement	10	10
Other programs	3	4
Medicaid	3	3
Veterans retirement	2	2
Housing	2	2
SSI	1	1

Sources:
U.S. Senate Special Committee on Aging (1984, p.42; 1986, p.122)

Table A9
Federal Spending on the Elderly
1965 - 2040

Year	P/GNP	H/GNP	B/GNP	B/Budget	Outlays
1965	4.1	0.3	4.4	24.9	
1970	4.7	1.4	6.1	30.0	
1975	6.4	2.0	8.4	37.1	
1980	6.5	2.3	8.8	38.2	
1982	7.1	2.7	9.7	39.6	
1984	7.0	2.8	9.8	39.7	$235,835.0a 27.7b
1985	-	-	-	-	263,564.5a 27.5b
1986	6.6	3.0	9.6	39.4	
1988	6.4	3.2	9.6	39.4	
1990	6.6	3.1	9.7	40.4	
1995	6.2	3.7	9.9	41.3	
2000	5.8	4.0	9.8	40.8	
2005	5.6	4.4	10.0	41.7	
2010	6.0	4.7	10.7	44.6	
2015	6.0	5.0	11.0	45.8	
2020	6.5	5.4	11.9	49.6	
2025	7.0	5.9	12.9	53.8	
2030	7.1	6.4	13.5	56.3	
2035	7.1	7.0	14.1	58.8	
2040	7.0	7.5	14.5	60.4	

Source:
U.S. Senate Special Committee on Aging (1986, pp.123,126) based on Palmer and Torrey (1983)

P/GNP: Pension programs as a percent of GNP
H/GNP: Health programs as a percent of GNP
B/GNP: Both programs as a percent of GNP
B/Budget: Both programs as a percent of budget

a: Federal outlays benefiting the elderly in millions of dollars
b: as a percent of total federal outlays

Table B1
Percent of AAA Directors by Salary Range
1982 and 1986

Salary Range	1982	1986
Less than $10,000	-	4.2
Less than 15,000	2.0	-
$10,000 -14,999	-	47.5
15,000 -19,999	28.0	35.0
20,000 -24,999	29.0	9.5
25,000 -29,999	17.0	1.6
More than 30,000	-	0.5
30,000 -34,999	19.0	-
35,000 -39,999	1.5	-
40,000 -44,999	2.0	-
More than 45,000	1.5	-

Sources: Levine (1983) for 1982, and Rodkin (1986a, p.12) for 1986.

Table B2
Average Teacher's Salary, 1985-86

State	Salary	State	Salary	State	Salary
Alabama	22,934	Alaska	41,480	Arizona	19,538
Arkansas	19,538	California	29,750	Colorado	25,900
Connecticut	26,619	Delaware	24,525	D.C.	33,990
Florida	22,296	Georgia	22,080	Hawaii	25,845
Idaho	20,969	Illinois	27,190	Indiana	24,333
Iowa	21,690	Kansas	22,768	Kentucky	20,940
Louisiana	20,460	Maine	19,583	Maryland	27,186
Mass	25,849	Michigan	30,168	Minnesota	26,970
Mississippi	18,443	Missouri	21,884	Montana	22,492
Nebraska	20,939	Nevada	20,148	N.C.	22,476
N.D.	20,816	N.H.	20,148	N.J.	28,216
N.M.	22,526	N.Y.	30,200	Ohio	24,500
Oklahoma	21,419	Oregon	25,788	Penn	26,009
R.I.	29,470	S.C.	21,428	S.D.	18,095
Tennessee	21,800	Texas	24,419	Utah	22,341
Vermont	20,325	Virginia	23,382	Washing	26,015
W.V.	20,625	Wisconsin	26,800	Wyoming	27,876
U.S.	25,257				

Source: National Education Association (1986).

Table C1
Median Family Income (MFI), and
Mean Family Income (MIF)
by Race/Ethnicity, 1980

Race	MFI	MIF
U.S.	$19,917	$23,092
White	20,835	24,166
Black	12,598	15,684
Hispanic*	13,712	17,263
Native**	13,723	16,648
Asian***	22,713	26,439
Japanese	27,354	30,527
Indian	24,990	29,591
Filipino	23,680	27,194
Chinese	22,559	26,600
Korean	20,450	24,670
Hawaiian	19,196	-
Guamanian	18,218	-
Samoan	14,242	-
All other	13,890	-
Vietnamese	12,840	15,271

Source: U.S. Bureau of the Census 1983a, p.51, Tables 93, 128, 138, 164; 1983b, p.2.

* Spanish Origin
** American Indian, Eskimo, and Aleutian
*** Asian and Pacific Islander

Table C2
Percent Minority in City (PMC), and
Percent Minority on AAA Staff (PMA)

City	PMC	PMA
Cleveland, Ohio	46.5	51.7
Bridgeport, Conn.	31.1	45.5
Tucson, Arizona	18.3	13.3
Tulsa, Oklahoma	17.4	50.0
San Francisco, Ca.	41.8	52.6
Honolulu, Hawaii	73.8	86.2

Source: Mastalish (1982, p.2)

Table C3
Percent I/A in City (PIC), and
Percent I/A on AAA Staff (PIA)

City	PIC	PIA
Cleveland, Ohio	0.8	0.0
Bridgeport, Conn.	0.7	0.0
Tucson, Arizona	2.4	0.0
Tulsa, Oklahoma	4.6	33.3
San Francisco, Ca.	22.2	26.3
Honolulu, Hawaii	72.7	82.8

I/A = American Indians and Asian/Pacific Islander

Source: Mastalish (1982, p.2)

Table C4
Percent Minority in City's Older Population (COP), and
Percent Minority Served with Title III-B Funds

City	COP	III-B		
Cleveland, Ohio	25.1	Chore 5.7	Health	19.0
		Tel Re 14.4	Homemaker	49.0
Bridgeport, Conn.	6.2	Friendly Visiting		50.0
		Legal Services		6.3
Tucson, Arizona	14.3	Chore 28.3	HHA	22.3
		Legal Services		31.3
Tulsa, Oklahoma	12.2	Homemaker/HHA		7.1
		Legal Services		4.9
San Francisco, Ca.	14.4	Chore 63.0	Legal	40.0
		Homemaker/Escort		80.5
Honolulu, Hawaii	74.4	Chore		66.9
		Friendly Visiting		90.4

Source: Mastalish (1982, p.3)

Table C5
Percent Minority in City's Older Population (COP), and
Percent Minority Served with Title III-C Funds

City	COP	III-C
Cleveland, Ohio	25.1	29.6
Bridgeport, Conn.	6.2	21.0
Tucson, Arizona	14.3	27.4
Tulsa, Oklahoma	12.2	9.7
San Francisco, Ca.	14.4	51.3
Honolulu, Hawaii	74.4	90.1

Source: Mastalish (1982, p.3)

Table C6
Percent of Families below Poverty (PFP), and of Families headed by the Aged below Poverty (FAP) by Race, 1979

Race	PFP	FAP
U.S.	9.6	12.4
White	7.0	9.4
Black	26.5	29.5
Hispanic	23.5	23.5
Native American	23.7	27.5
Asian American	10.7	13.1

Source: U.S. Bureau of the Census (1983a, Tables 97, 129; 1984, Table 96).

Table C7
Minority Participation in Title III Services

Year	Total	Minorities
III-B Supportive Services		
1980	9,336,993	2,047,007 (21.9)
1981	8,885,747	1,607,229 (18.1)
1982	9,160,079	1,653,980 (18.1)
1983	9,171,609	1,625,390 (17.7)
1984	9,126,122	1,597,589 (17.5)
1985	9,331,154	1,535,112 (16.5)
III-C Nutrition Services		
1980	3,083,454	585,584 (19.0)
1981	3,400,952	644,203 (18.9)
1982	3,355,778	603,996 (18.0)
1983	3,759,222	705,258 (18.8)
1984	3,530,288	610,052 (17.3)
1985	3,630,177	595,619 (16.4)

Source: NCBA (1987, p.62)

Table C8
Aged Black Participation in Supportive and Nutrition Services

Year	Supportive Services	Nutrition Services
1980	1,297,767 (13.9)	346,487 (11.2)
1981	1,052,762 (11.8)	378,782 (11.1)
1982	1,049,617 (11.5)	345,593 (10.3)
1983	1,074,810 (11.7)	376,518 (10.0)
1984	1,034,958 (11.3)	380,297 (10.7)
1985	1,000,302 (10.7)	366,697 (10.1)

Source: NCBA (1987, p.63).

APPENDIX D1

Host Agencies

LOUISIANA STATE DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Human Development
Division of Children, Youth, and Family Services
Monroe Regional Office
State Office Building, Room 450
122 Saint John Street
Monroe, La. 71201
318-362-3362

Mrs. Earline O. Coody, Administrator
Mrs. Jackie Harrell, Administrator
(Succeeding Mrs. Coody upon her retirement)

Mrs. Helen Butitta, East District Supervisor
c/o Monroe Regional Office

Mrs. Melba Sandifer, Parish Manager
OHD/DCYFS West Carroll Parish Office
P.O. Box 728
Oak Grove, La. 71263
318-428-3252/559-2904

Miss Cathy J. Hopkins, West District Supervisor
c/o Monroe Regional Office

Mr. Van Rogers, Parish Manager
OHD/DCYFS Union Parish Office
P.O. Box 490
Farmerville, La. 71241
318-368-3166

OUACHITA COUNCIL ON AGING/Area Agency on Aging
1209 Oliver Road
Monroe, La. 71201
318-387-0535
Mr. Joseph Nastasi, Director

(continued in next page)

NORTH DELTA AREA AGENCY ON AGING
2155 Justice Street
Monroe, La. 71201
318-387-2572
Mrs. LaNell Winston, Director

East Carroll Council on Aging
806 First Street
Lake Providence, La. 71254
318-559-2804
Mrs. Mary Knight, Director

Franklin Council on Aging
2108 Loop Road
Winnsboro, La. 71295
318-435-7579
Mrs. Carolyn Ezell, Director

Jackson Council on Aging
P.O. Box 599
Jonesboro, La. 71251
318-259-2265
Mrs. Francine Zuber, Director

Richland Council on Aging
P.O. Box 32
Rayville, La. 71269
318-359-6078
Mrs. Martha Stephens, Director

Union Council on Aging
102 Railroad
Farmerville, La. 71241
318-449-5439
Mrs. Louise Denton, Director

APPENDIX D2

Interns

Alford, Anna
OHD/DCYFS West Carroll Office
Agency Supervisor: Mrs. Melba Sandifer
Project Liaison: Dr. Joanne Rhone

Douglas, Antoinnette
Franklin Council on Aging
Agency Supervisor: Mrs. Carolyn Ezell
Project Liaison: Dr. Larcy McCarley

Dunn, Sarah
OHD/DCYFS Union Parish Office
Agency Supervisor: Mr. Van Rogers
Project Liaison: Mrs. Jannette Russell

Green, Pamelia
North Delta Area Agency on Aging
Agency Supervisor: Mrs. LaNell Winston
Project Liaison: Mr. Terry McPhearson

Green, Terri
Ouachita Council on Aging
Agency Supervisor: Mrs. Margaret Land
Project Liaison: Mr. Terry McPhearson

Grover, Brenda
East Carroll Council on Aging
Agency Supervisor: Mrs. Mary Knight
Project Liaison: Dr. Joanne Rhone

Pace, Jacqueline
Brown, Marion
(replacing Pace upon her employment)
Agency Supervisor: Mrs. Francine Zuber
Project Liaison: Mrs. Jannette Russell

APPENDIX D3

LETTER OF AGREEMENT

Grambling State University, School of Social Work, Minority Management Internship in Aging Project (Project) and Louisiana State Department of Health and Human Resources, Office of Human Development, Division of Children, Youth, and Family Services, Monroe Regional Office (Agency) enter into the following agreement:

1. The Agency shall accept two interns for a period of 12 months beginning 9/1/86 and ending 8/31/87.

2. The Agency and the Project shall conduct a joint interview of applicants.

3. The final selection of two interns shall be determined by mutual agreement of the Agency and the Project.

4. One intern will be placed in the Union Parish Office, and another in the West Carroll Parish Office. The Agency is given the authority to change assignments.

5. The Agency shall offer a meaningful and appropriate training and experience consistent with the intern's educational background.

6. The Agency shall provide interns with a "job" description, i.e., a description of duties and responsibilities, a copy of which shall be made available to the Project.

7. The Agency shall provide interns with an appropriate and sufficient supervision for their training and practice.

8. The Agency shall appoint a supervisor for each intern for his/her day-to-day activities.

9. The Project shall appoint a liaison for monthly conferences at the Agency. The Agency shall allow the intern and the supervisor to meet with the Project liaison for conferences and evaluations.

10. The Agency shall allow the intern to attend monthly seminars at the Project office.

11. The Agency, or the Project, is allowed to request for additional meetings, if necessary.

(continued in next page)

12. If an intern is judged to be making unsatisfactory progress or achievement, he/she can be dismissed prior to reaching the full 12-month term upon mutual agreement of the Agency and the Project.

13. Commuting to and from the Agency is the responsibility of the intern. The Agency shall reimburse mileage and, if applicable, per diem for the intern's trips taken on Agency business.

14. The Project shall reimburse the travel expenses of the interns for their trips to the Project office for the monthly seminars.

15. The Agency is given discretion to recommend a conference or workshop for the intern to attend, if such a meeting is deemed beneficial and directly related to the intern's training. The Project shall reimburse such travels.

16. Interns are expected to follow all rules and regulations of the Agency including those with respect to working hours, punctuality for work, client appointments, dress code, if any, office conduct and confidentiality of all case materials. The Agency supervisor shall monitor these in addition to other progress reports.

17. The internship is for full-time, and all interns are required to report to work every day for a full day except on weekends and official holidays of the Agency. No annual leave or sick leave is allowed.

18. The Project shall pay a stipend of $1,000 per month to each intern on or before the last day of each month.

For the Project

Pill Jay Cho, Ph.D.
Project Director

For the Agency

Earline O. Coody, ACSW
Regional Administrator

APPENDIX D4

LETTER OF UNDERSTANDING

1. I understand that this internship is made available through a grant made by the U.S. Administration on Aging (AoA) to the Grambling State University School of Social Work Minority Management Internship in Aging (Project).

2. I understand that my internship will take place in the Louisiana State Department of Health and Human Resources, Office of Human Development, Division of Children, Youth, and Family Services, Monroe Regional Office (Agency).

3. I understand that the Agency in consultation with the Project will assign a supervisor to me for my training and work experience in services to the elderly.

4. I understand that the Agency will provide me with a description of my duties and responsibilities, and other training and work assignments deemed appropriate for this internship.

5. I understand that the Project will assign a faculty liaison to me for consultation, feedback, and evaluation of my internship.

6. I understand that this internship is for a period of 12 months beginning 9/1/86 and ending 8/31/87.

7. I understand that this internship is for full-time, and I am expected to work every day for a full day except on weekends and Agency holidays.

8. I understand that this is an internship, not an employment, and that no annual leave or sick leave is allowed.

9. I understand that I must observe all rule and regulations of the Agency including those with respect to working hours, punctuality for work, client appointments, dress code, if any, office conduct and confidentiality of all case materials.

10. I understand that there will be monthly conferences at the Agency to be attended by me and my supervisor to meet with the Project liaison for consultation, progress monitoring, and evaluation of my performance.

11. I understand that there will be monthly seminars at the Project to be attended by me and my supervisor for feedback, training, and progress evaluation.

(continued in next page)

12. I understand that the Agency, the Project, or I can ask for a special meeting, if necessary, in addition to monthly conferences and seminars.

13. I understand that my internship is contingent on satisfactory progress and can be terminated prior to 8/31/87, if and when the Agency and the Project jointly determine that such action is to the best interest of all parties concerned.

14. I understand that I have to keep a daily activity log and other documentation of my internship for the monthly conferences. These records will be used only for the purpose of evaluating my progress as an intern and to enhance and improve my knowledge and skills in working with the elderly and related administrative tasks.

15. I understand that I must submit a final report to the Project upon completion of my internship. The topic of my report shall be determined by me after discussion with my supervisor and liaison.

16. I understand that I will receive a stipend of $1,000 a month for my internship until this internship expires or as long as maintain my internship in good standing within the 12-month training period.

17. I understand that the original of this Letter will be kept in the Project office, and a copy in the Agency, and that I keep a copy.

_____

Intern

_____

Witness

APPENDIX D5

Monthly Conference Reports

Date: 3/13/87
To: Pill Cho
From: Terry McPhearson
Re: Site Visit

On 3/12/87 I visited North Delta Area Agency on Aging in Monroe for a conference with Pam Green and her supervisor, Mrs. Winston. Mrs. Winston is quite enthusiastic about Pam and her work. She said that Pam was well accepted by the agency staff, confident and responsible. She gave as an example an incident happened lately. Mrs. Winston and Pam were scheduled to visit a nursing home in Rayville on a particular day. The morning of that day Mrs. Winston could not report to work and called Pam and suggested that she cancel the appointment. Pam explained that the appointment had been made and that they would be expecting them and she would fill the engagement alone. Mrs. Winston later received a favorable feedback from the nursing home regarding Pam's presentation.

Pam continues to work on her case management assignment and has now taken on two new assignments. She is attending classes to be certified as an Ombudsman and has been given responsibility for a special program for the elderly developed by the Louisiana Endowment for Humanities. After receiving appropriate training by the Endowment, she will be presenting the humanities program to the nursing homes in the North Delta region. Mrs. Winston is trying to retain Pam as a permanent employee upon her completion of the internship.

Pam likes her work very much and told me that she was learning a lot and also enjoying her internship. This is a good placement, for both the agency and the intern are benefiting from it.

APPENDIX D6

Intern Performance Evaluation Form

Intern _____

Agency Supervisor _____

Project Liaison _____

For each item below, assign a number 1 (very poor), 2 (poor), 3 (average), 4 (good), or 5 (excellent). If an item is not applicable, do not leave the space blank but write N.

A. Agency Practice and Procedures
The intern demonstrates knowledge or understanding of:

___ agency philosophy, goals, purposes, objectives, or mandates.

___ agency function and structure.

___ agency funding sources and mechanisms.

___ agency personnel policy.

___ agency rules and regulations governing the delivery of services to clients.

___ needs of clients served by the agency.

___ agency's strengths and limitations.

___ agency's relationships with other human service organizations in the community.

B. Functioning within Agency
The intern:

___ is punctual and dependable.

___ uses time appropriately.

___ handles routine assignments satisfactorily.

___ completes assignments and tasks as scheduled.

(continued in next page)

___ relates appropriately to clients.

___ develops working relationships with agency staff.

___ actively participates in supervisory conferences.

___ sets priorities and adheres to them.

___ maintains professional confidentiality.

___ completes written communication.

___ makes oral presentations.

___ works independently.

___ uses phone with professional courtesy.

___ appropriately applies agency policies, rules, and regulations to achieve objectives.

C. Values and Attitudes
The intern:

___ articulates values and principles appropriate for services to the elderly.

___ integrates these values and principles into gerontological practice.

___ is aware of personal values, prejudice, and bias.

___ makes efforts to cope with bias.

___ is able to separate personal values from client's when two are different.

___ accepts clients of different social or demographic characteristics such as race, gender, sexual preference, religion, class, and physical or mental handicap.

D. Engagement and Skill Development
The intern is able to:

___ develop meaningful and professional relationships with clients.

(continued in next page)

___ understand the need of clients.

___ explain agency policy to clients in simple terms.

___ collect data related to the problem identified (scope, duration, severity, etc.).

___ collect data related to the persons involved (coping capacity, ability to improve functioning, strengths and weaknesses, motivation, etc.).

___ collect data related to the environment (formal and informal systems, etc.).

___ assess problems in relation to normal growth and development.

___ determine appropriate intervention.

___ observe and report client's behavior.

___ analyze and assess client's behavior and reactions.

___ establish and use relationship in the provision of services.

___ use exploration.

___ focus.

___ verbally recognize client's feelings with client.

___ partialize feelings and problems.

___ be professionally supportive.

___ use confrontation.

___ set limits.

___ accept clients of different social and demographic characteristics.

___ respect confidentiality.

___ respect for client's right to self-determination.

___ accurately record facts, observations, actions, and responses of clients.

___ skillfully write psychosocial and other summaries.

(continued in next page)

___ organize and present information orally.

___ write assessment statements clearly.

___ prioritize problems with clients.

___ develop contracts with clients.

___ accomplish agreed upon tasks in contract.

___ understand interventive strategies.

___ select or suggest interventive resources/strategies with sensitivity to client's sociocultural and demographic characteristics.

___ assess effectiveness of contract.

___ assess treatment plan.

___ make evaluation process decision regarding termination.

___ plan for termination.

___ demonstrates sensitivity in terminating process.

E. Assessment
The intern:

___ can assess his/her own skill development and effectiveness.

___ can clarify areas in which growth will enhance service delivery and skill effectiveness.

___ can assess service delivery system.

___ demonstrates skill in use of self in professional relations.

___ demonstrates beginning skill in assessing agency policy and procedures for achievement of agency goals.

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